NEW YORK STATE

EPIC
Elderly Pharmaceutical Insurance Coverage Program

Application

NEED HELP? CALL TOLL-FREE: 1-800-332-3742
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Please print clearly!

Who is applying and for? ☐ Yourself **only** ☐ Yourself **and your spouse** ☐ "Extra Help" **only**

Your Last Name | First | Middle Initial

c/o Name (if different from above)

Address Where You Live (not P.O. Box)

City | State | ZIP Code

Address Where You Get Your Mail (if different from above)

City | State | ZIP Code

Social Security Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Sex

☐ Female ☐ Male ☐ X

Your Date of Birth

Month / Day / Year

_____ / _____ / _____

Your Telephone Number

Area Code Number

(_____) _____

Marital Status

☐ Widowed, Single or Divorced
☐ Married, Living Together
☐ Married, Living Separately

Spouse's Name (If Living)

Last Name | First | Middle Initial

Spouse's Telephone Number

Area Code Number

(_____) _____

Spouse's Social Security Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Spouse's Date of Birth

Month / Day / Year

_____ / _____ / _____

Spouse's Sex

☐ Female ☐ Male ☐ X

Enter your Medicare Claim Number (blue, white and red card) _____

Enter your Spouse's Medicare Claim Number (blue, white and red card) _____

If you already have EPIC, enter your EPIC Identification Number _____

If your spouse has EPIC, enter your Spouse's EPIC Identfication Number _____

EPIC Determination: Report your total income for the previous calendar year.

If you are married, and living together, you must report the combined yearly income for the previous year for you and your spouse even if only one of you is applying. If married but living apart, report only your yearly income. Multiply monthly amounts by 12 to get yearly income. Lines 1-3 are used only for your EPIC determination.

	Your Yearly Income	Spouse's Yearly Income
1. Social Security and/or Railroad Retirement Benefits, (less Medicare Part B premiums) paid to you by check or direct deposit.	$ _____	$ _____
2. Other Income: Include Pensions, Annuities, Interest, Dividends, IRA Distributions, Capital Gains, Wages, Business Income or Losses, Net Rental Income, etc.	$ _____	$ _____
3. Total YEARLY Income (Add lines **1** and **2**)	$ _____	$ _____

(Please fill in pages 2 and 3)

"Extra Help" Determination: Report your total current monthly income.

EPIC will use your answers to lines 4-22 to apply for a federal benefit called "Extra Help" on your behalf. This is required by law to obtain EPIC benefits. If you already receive "Extra Help" benefits proceed to line 23 (skip lines 4-22) to indicate that you are providing a copy of your determination letter.

CURRENT MONTHLY AMOUNTS (Enter $0 if no income)	**Your Income**	**Spouse's Income**
4. Monthly Social Security before deductions	$	$
5. Monthly Railroad Retirement before deductions	$	$
6. Monthly Veterans Benefits before deductions	$	$
7. Monthly – Other pensions and annuities before deductions (not including any amount reported in the **Assets** section below)	$	$
8. Monthly – Other income not listed above (including alimony, net rental income, workers' compensation, private or state disability payments)	$	$
8A. Specify TYPE of other income (line 8):		
9. Total MONTHLY Income (Add lines **4-8**)	$	$

If your income exceeds the limit placed on "Extra Help" for the calendar year you are applying in (see EPIC's web site at http://health.ny.gov/health_care/epic/medicare.htm or the Social Security Administration web site at http://www.ssa.gov), please skip lines 10-22 then continue. If you do not have Internet access, call the EPIC Helpline at: 1-800-332-3742 (TTY 1-800-290-9138).

10. Have any amounts reported on lines **4-8** decreased during the last two years? ☐ Yes ☐ No

11. Bank accounts – total current balance (checking, savings, money market, certificates of deposit) $ _____

12. Stocks, bonds, savings bonds, mutual funds Individual Retirement Accounts or other similar investments $ _____

13. Cash at home or anywhere else $ _____

14. Total Assets (Add lines **11-13**). $ _____

If your assets exceed the limit placed on"Extra Help" for the calendar year you are applying in (see EPIC's web site at http://health.ny.gov/health_care/epic/medicare.htm or similar information at CMS's web site), please skip lines 15-22 and proceed with signing.

15. Will your assets be used for funeral or burial expenses? ☐ Yes ☐ No

16. Do you own real estate other than your home? ☐ Yes ☐ No

17. How many relatives living with you depend on you to provide at least one-half of their financial support? (do not include you or your spouse) _____

18. What do you expect to earn in wages before taxes and deductions this calendar year? You: $ _____ Spouse: $ _____

19. If self-employed, what are your expected net earnings or loss this calendar year? You: $ _____ Spouse: $ _____

20. Have the amounts reported for lines **18** or **19** decreased in the last two years? ☐ Yes ☐ No

21. If you recently stopped working or plan to stop working, enter the month and year (example: 09/2018) You: ___ ___ / 20 ___ ___ Spouse: ___ ___ / 20 ___ ___

(Please fill in page 3)

22. **If your spouse is younger than 65 and is blind or disabled,** do you or your spouse pay for things that enable your spouse to work? ☐ Yes ☐ No ☐ N/A

23. **If you are already qualified for Medicare Savings Program and receiving "Extra Help" benefits,** have you attached a copy of your determination letter? ☐ Yes ☐ No ☐ N/A

If someone assisted you in completing this form, please provide their name, address and phone number.

Print Name

Phone Number (including area code)
( )

Mailing Address

City/State/ZIP Code

Read carefully and sign below:

I certify that the information on this form is correct. I reside in New York State and am not currently receiving full Medicaid benefits. I know that I am required to give proof of my age, income, residency, Medicare status and Medicare Part D drug plan, if any. I also know that I am required to enroll in a Medicare Part D drug plan in order to be enrolled in EPIC. I understand that failure to provide identifying information necessary to enroll in a Part D plan, or the Medicare subsidy (Extra Help), if eligible, may result in termination of EPIC coverage. I consent to the exchange of all information necessary to verify my eligibility among and between EPIC, the Social Security Administration, Medicare, the NYS Medicaid Program, the NYS Tax Department, Medicare Part D drug plans, and any other necessary entities. In the event of duplicate or overpayment by EPIC, I assign to EPIC any drug benefits that I may be entitled to under any Part D or governmental plan. I authorize my health care providers to release to the EPIC program my medical information pertaining to prescriptions and/or diagnosis to be used for payment, audit or related health care operations.

You (and your spouse if living together) must sign below:

Your signature (legal representation)

Date

Spouse's signature (legal representation)

Date

Caution: If you are "Extra Help" eligible and do not either complete lines 4-22 or provide a copy of your Social Security Determination Letter, then your application will be considered incomplete.

Mail this completed form to: **EPIC**
P.O. Box 15018
Albany, NY 12212-5018
or Fax: (518) 452-3576

NEW YORK STATE

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