NEW YORK STATE

EPIC
Elderly Pharmaceutical Insurance Coverage Program

Application

NEED HELP? CALL TOLL-FREE: 1-800-332-3742
¿NECESITA AYUDA? LLAME AL: 1-800-332-3742

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

Spouse's Name (If Living)

Last Name | First | Middle Initial

Spouse's Telephone Number

Area Code Number
( ) _____

Social Security Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Sex

☐ Female ☐ Male

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 Social Security Number

___ ___ ___ ___ ___ ___ ___ ___ ___

Spouse's Date of Birth

Month / Day / Year

Spouse's Sex

☐ Female ☐ Male

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**)	$	$

"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**)	$	$

(Please fill in page 2)

cut off and keep

EPIC Rate Schedules

Shaded areas – Your EPIC deductible will be less than the amount shown.

Fee Plan Schedule

Single

Annual Income	Annual Fee
Up to $6,000	$8
$ 6,001 – $ 7,000	$16
$ 7,001 – $ 8,000	$22
$ 8,001 – $ 9,000	$28
$ 9,001 – $10,000	$36
$10,001 – $11,000	$40
$11,001 – $12,000	$46
$12,001 – $13,000	$54
$13,001 – $14,000	$60
$14,001 – $15,000	$80
$15,001 – $16,000	$110
$16,001 – $17,000	$140
$17,001 – $18,000	$170
$18,001 – $19,000	$200
$19,001 – $20,000	$230
Over $20,000	See Deductible Plan

Married

Joint Annual Income	Annual Fee (Each Person)
Up to $ 6,000	$ 8
$ 6,001 – $ 7,000	$12
$ 7,001 – $ 8,000	$16
$ 8,001 – $ 9,000	$20
$ 9,001 – $10,000	$24
$10,001 – $11,000	$28
$11,001 – $12,000	$32
$12,001 – $13,000	$36
$13,001 – $14,000	$40
$14,001 – $15,000	$40
$15,001 – $16,000	$84
$16,001 – $17,000	$106
$17,001 – $18,000	$126
$18,001 – $19,000	$150
$19,001 – $20,000	$172
$20,001 – $21,000	$194
$21,001 – $22,000	$216
$22,001 – $23,000	$238
$23,001 – $24,000	$260
$24,001 – $25,000	$275
$25,001 – $26,000	$300
Over $26,000	See Deductible Plan

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Deductible Plan Schedule

Single

Annual Income	Annual Deductible
Under $20,000	See Fee Plan
$20,001 – $21,000	$530
$21,001 – $22,000	$550
$22,001 – $23,000	$580
$23,001 – $24,000	$720
$24,001 – $25,000	$750
$25,001 – $26,000	$780
$26,001 – $27,000	$810
$27,001 – $28,000	$840
$28,001 – $29,000	$870
$29,001 – $30,000	$900
$30,001 – $31,000	$930
$31,001 – $32,000	$960
$32,001 – $33,000	$1,160
$33,001 – $34,000	$1,190
$34,001 – $35,000	$1,230
$35,001 – $36,000	$1,260
$36,001 – $37,000	$1,290
$37,001 – $38,000	$1,320
$38,001 – $39,000	$1,350
$39,001 – $40,000	$1,380
$40,001 – $41,000	$1,410
$41,001 – $42,000	$1,440
$42,001 – $43,000	$1,470
$43,001 – $44,000	$1,500
$44,001 – $45,000	$1,530
$45,001 – $46,000	$1,560
$46,001 – $47,000	$1,590
$47,001 – $48,000	$1,620
$48,001 – $49,000	$1,650
$49,001 – $50,000	$1,680
$50,001 – $51,000	$1,710
$51,001 – $52,000	$1,740
$52,001 – $53,000	$1,770
$53,001 – $54,000	$1,800
$54,001 – $55,000	$1,830
$55,001 – $56,000	$1,860
$56,001 – $57,000	$1,890
$57,001 – $58,000	$1,920
$58,001 – $59,000	$1,950
$59,001 – $60,000	$1,980
$60,001 – $61,000	$2,010
$61,001 – $62,000	$2,040
$62,001 – $63,000	$2,070
$63,001 – $64,000	$2,100
$64,001 – $65,000	$2,130
$65,001 – $66,000	$2,160
$66,001 – $67,000	$2,190
$67,001 – $68,000	$2,220
$68,001 – $69,000	$2,250
$69,001 – $70,000	$2,280
$70,001 – $71,000	$2,310
$71,001 – $72,000	$2,340
$72,001 – $73,000	$2,370
$73,001 – $74,000	$2,400
$74,001 – $75,000	$2,430
Over $75,000	Not Eligible

Married

Joint Annual Income	Annual Deductible (Each Person)
Under $26,000	See Fee Plan
$26,001 – $27,000	$650
$27,001 – $28,000	$675
$28,001 – $29,000	$700
$29,001 – $30,000	$725
$30,001 – $31,000	$900
$31,001 – $32,000	$930
$32,001 – $33,000	$960
$33,001 – $34,000	$990
$34,001 – $35,000	$1,020
$35,001 – $36,000	$1,050
$36,001 – $37,000	$1,080
$37,001 – $38,000	$1,110
$38,001 – $39,000	$1,140
$39,001 – $40,000	$1,170
$40,001 – $41,000	$1,200
$41,001 – $42,000	$1,230
$42,001 – $43,000	$1,260
$43,001 – $44,000	$1,290
$44,001 – $45,000	$1,320
$45,001 – $46,000	$1,575
$46,001 – $47,000	$1,610
$47,001 – $48,000	$1,645
$48,001 – $49,000	$1,680
$49,001 – $50,000	$1,715
$50,001 – $51,000	$1,745
$51,001 – $52,000	$1,775
$52,001 – $53,000	$1,805
$53,001 – $54,000	$1,835
$54,001 – $55,000	$1,865
$55,001 – $56,000	$1,895
$56,001 – $57,000	$1,925
$57,001 – $58,000	$1,955
$58,001 – $59,000	$1,985
$59,001 – $60,000	$2,015
$60,001 – $61,000	$2,045
$61,001 – $62,000	$2,075
$62,001 – $63,000	$2,105
$63,001 – $64,000	$2,135
$64,001 – $65,000	$2,165
$65,001 – $66,000	$2,195
$66,001 – $67,000	$2,225
$67,001 – $68,000	$2,255
$68,001 – $69,000	$2,285
$69,001 – $70,000	$2,315
$70,001 – $71,000	$2,345
$71,001 – $72,000	$2,375
$72,001 – $73,000	$2,405
$73,001 – $74,000	$2,435
$74,001 – $75,000	$2,465
$75,001 – $76,000	$2,495
$76,001 – $77,000	$2,525
$77,001 – $78,000	$2,555
$78,001 – $79,000	$2,585
$79,001 – $80,000	$2,615
$80,001 – $81,000	$2,645
$81,001 – $82,000	$2,675
$82,001 – $83,000	$2,705
$83,001 – $84,000	$2,735
$84,001 – $85,000	$2,765
$85,001 – $86,000	$2,795
$86,001 – $87,000	$2,825
$87,001 – $88,000	$2,855
$88,001 – $89,000	$2,885
$89,001 – $90,000	$2,915
$90,001 – $91,000	$2,945
$91,001 – $92,000	$2,975
$92,001 – $93,000	$3,005
$93,001 – $94,000	$3,035
$94,001 – $95,000	$3,065
$95,001 – $96,000	$3,095
$96,001 – $97,000	$3,125
$97,001 – $98,000	$3,155
$98,001 – $99,000	$3,185
$99,001 – $100,000	$3,215
Over $100,000	Not Eligible

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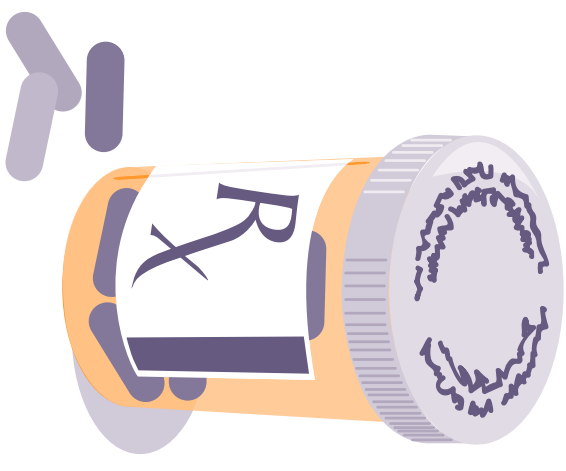
For more information call the toll-free EPIC Helpline at
1-800-332-3742 (TTY 1-800-290-9138)
Download an application at:
http://health.ny.gov/health_care/epic/application_contact.htm
choose which language version
or write to:
EPIC
P.O. Box 15018
Albany, NY 12212-5018.

The Elderly Pharmaceutical Insurance Coverage program (EPIC) saves you more money on the cost of your prescription drugs by supplementing your Medicare Part D plan.

Who can join?

- A resident of New York State 65 or older with annual income up to $75,000 if single or $100,000 if married.
- An eligible senior with a Medicaid spend down not receiving full Medicaid benefits.



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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 ___ ___

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 | **EPIC** Elderly Pharmaceutical Insurance Coverage Program

The information on this application is kept strictly confidential and is used only to determine your eligibility for EPIC as well as to apply for the federal benefit "Extra Help" on your behalf, as required by law.

cut off and keep

NEW YORK STATE | **EPIC** Elderly Pharmaceutical Insurance Coverage Program

What is EPIC?

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program administered by the Department of Health. It provides seniors with co-payment assistance for Medicare Part D covered prescription drugs **after any Part D deductible is met.** EPIC also covers many Medicare Part D excluded drugs.

- **Fee Plan** members pay an annual fee to EPIC based on their income. The EPIC co-payments range from $3 - $20 based on the cost of the drug. Those with Full Extra Help from Medicare have their EPIC fee waived.
- **Deductible Plan** members must meet an annual out-of-pocket deductible based on their income before paying EPIC co-payments for drugs.

EPIC also pays Medicare Part D plan premiums, up to the amount of a basic plan, for members with annual income below $23,000 if single or $29,000 if married.

Those with higher incomes must pay their Part D plan premiums.

- To help them pay, their EPIC deductible is lowered by the annual cost of a Medicare Part D basic plan.
- EPIC deductibles for income in shaded areas on the Deductible Plan schedule will be less than the amounts shown.

Medicare Part D Enrollment

***All* EPIC members must have Part D** in order to receive EPIC benefits. Because EPIC is a qualified State Pharmaceutical Assistance Program, members are able to join a Part D plan during the year once enrolled in EPIC. They also can change their Medicare Part D plan one time during the year.

"Extra Help" can save money!

EPIC will use the information on this application to apply for Extra Help on the senior's behalf, if income eligible, and only lines 1-3 will be used for EPIC determination.

- Seniors who already receive Extra Help can send a copy of their determination letter from Social Security Administration with their form.
- If approved for full Extra Help, the senior will have lower co-payments and will not have a Medicare Part D coverage gap. Medicare and EPIC will pay all or most of the monthly Part D plan premium.

How to Apply

- Complete the application, sign it and mail it to the address below.
- Report the total income for you and your spouse if living together (even if only one is applying) and both must sign the form.
- Apply separately or spouses living together can both use the same form. Check 'Single' if you are single, divorced, widowed, or your spouse does not live with you (example: in a nursing home). Check 'Married' if you and your spouse live in the same household.

Previous Year Income

Lines 1-3 are used for your EPIC determination. If you are MARRIED and living with your spouse, fill in information for both of you. Using the amount(s) on Line 3, refer to the EPIC Rate Schedule on the reverse of this page to determine your Plan and based on your income, your annual fee or your annual deductible.

Qualifying for Extra Help

Seniors already qualified for Medicare Savings Programs are automatically qualified for Extra Help. Please send a copy of your determination letter. You may skip Lines 4 through 22 if you are qualified.

Current Monthly Income

- Lines 4-9. Please enter the current monthly income before deductions for each type i.e., social security, veterans. If the amount changes month to month, estimate the average monthly income for the past 12 months for each line. Do NOT include wages and self-employment, interest income, dividends, public assistance, medical reimbursements or foster care payments. Please enter $0 if you have no income to report on that line.
- Line 8a. Please specify the TYPE of other income that you or your spouse is reporting on Line 5, such as alimony, net rental income, workers compensation, or private or state disability payments, etc.
- Line 10. Indicate whether any of the amounts reported on lines 4-8 decreased in the last two years.

Assets

- Lines 11-14. Please report the current balance (or estimate) for the bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own. Include cash or investments that either of you own with another person. **Do NOT include your home, vehicles, burial plots, personal possessions, or back payment from Social Security or Social Security Income (SSI). On each line, enter $0 if none.**

Other Expenses and Earnings

If you are SINGLE, please answer questions (12-14) based on your income and assets. If you are MARRIED and living with your spouse, please answer questions (12-14) based on your COMBINED income and assets, where applicable.

- Line 15. Please check yes if you expect cash or money from any investments listed under Assets on lines (8-10) will be used to pay for funeral or burial expenses for you or your spouse. Otherwise, check no.
- Line 16. Please check yes if you or your spouse own real estate other than your home (examples: summer home, rental properties or undeveloped land which is separate from your home). Otherwise, check no.
- Line 17. Please enter the number of relatives that live with you that depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption. Enter a 0 if this question is not applicable.

Answer questions 18-22 only if you and your spouse (if living together) HAVE worked in the last two years. Otherwise, please leave questions 18-22 blank.

- Line 18. Please estimate the amount you or your spouse expect to earn in wages **before taxes and deductions** this calendar year.
- Line 19. If self-employed, please estimate the amount you or your spouse expect to earn or lose this calendar year. Please enter a negative number if you expect a loss.
- Line 20. Please check yes if the amounts reported on Lines 18 or 19 decreased in the last two years. Otherwise, check no.
- Line 21. Please enter the month and year (MM/YYYY) that you stopped working or plan to stop working. Please leave this blank if you or your spouse plan to continue working.
- Line 22. Please check either yes or no if you or your spouse pay for things that allow your spouse to work. Examples of such expenses are: a wheelchair; cost of medical treatment and drugs for illnesses; personal attendant services; vehicle modifications or other transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations. Please check N/A (not applicable) if single or your spouse is 65 or older.
- Line 23. Please ensure you attach a copy of your determination letter should you already be receiving "Extra Help" benefits.