



**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

**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 Identification 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.	\$ <input type="text"/>	\$ <input type="text"/>
2. Other Income: Include Pensions, Annuities, Interest, Dividends, IRA Distributions, Capital Gains, Wages, Business Income or Losses, Net Rental Income, etc.	\$ <input type="text"/>	\$ <input type="text"/>
<b>3. Total YEARLY Income (Add lines 1 and 2)</b>	\$ <input type="text"/>	\$ <input type="text"/>

**"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 <b>Assets</b> section below)	\$ _____	\$ _____
8. Monthly – Other income not listed above (including alimony, net rental income, workers' compensation, private or state disability payments)	\$ _____	\$ _____
<b>8A. Specify TYPE of other income (line 8):</b>	_____	_____
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](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](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**



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