Report your total income for the previous calendar year.

- **If you are married, and living together, you must report the combined yearly income 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.**

	Your Yearly Income	Spouse's Yearly Income
1. Social Security and/or Railroad Retirement Benefits, *(less Medicare 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**)	$ _____	$ _____

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, 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 married and living together), must sign below:

Your signature (legal representation) _____ Date _____

Spouse's signature (legal representation) _____ Date _____

Authorization (OPTIONAL): I agree that EPIC can disclose my information to the following persons/family members who are involved in my health care as necessary to process my EPIC benefits.

Please print names _____

Mail this completed form to: **EPIC**
P.O. Box 15018
Albany, NY 12212-5018

or Fax: (518) 452-3576

NEW YORK state department of HEALTH

New York State and Medicare EPIC Working Together

The information on this application is kept strictly confidential and is used only to determine your eligibility for EPIC.

Guide to the Elderly Pharmaceutical Insurance Coverage program (EPIC)

Courtesy of:

Assemblyman Alfred C. Graf
991 Main Street, Suite 202 • Holbrook, NY 11741 • 631-585-0230
Room 433, LOB • Albany, NY 12248 • 518-455-5937
grafa@assembly.state.ny.us

2013 EPIC

Assemblyman
Alfred C. Graf

All Elderly Pharmaceutical Insurance Coverage program (EPIC) members must have Medicare Part D in order to receive EPIC benefits. Because EPIC is a qualified State Pharmaceutical Assistance Program, EPIC members can change their Medicare Part D plan one time during the year, in addition to the open enrollment period.

Updated 4/13

EPIC has two plans:

1. FEE PLAN

Members pay an annual fee to EPIC based on their income. Those with Full Extra Help from Medicare have their fee waived. Co-payments (see chart below) are effective immediately.

If you are single:

Annual income range	Annual fee range
$6,000 or less	$8
$6,001-$9,000	$16-$28
$9,001-$11,000	$36-$40
$11,001-$15,000	$46-$80
$15,001-$17,000	$110-$140
$17,001-$19,000	$170-$200
$19,001-$20,000	$230
Over $20,000	See Deductible Plan

If you are married:

Annual joint income	Annual fee person
$6,000 or less	$8
$6,001-$10,000	$12-$24
$10,001-$13,000	$28-$36
$13,001-$15,000	$40
$15,001-$18,000	$84-$126
$18,001-$21,000	$150-$194
$21,001-$24,000	$216-$260
$24,001-$26,000	$275-$300
Over $26,000	See Deductible Plan

2. DEDUCTIBLE PLAN

Members **must** meet an annual out-of-pocket deductible based on their income before paying EPIC co-payments (see chart below) for drugs.

If you are single:

Annual income range	Deductible range
$20,001-$22,000	$530-$550
$22,001-$24,000	$580-$720
$24,001-$26,000	$750-$780
$26,001-$28,000	$810-$840
$28,001-$30,000	$870-$900
$30,001-$33,000	$930-$1,160
$33,001-$35,000	$1,190-$1,230
Over $35,000	Not Eligible

If you are married:

Joint annual income range	Deductible range for each person
$26,001-$29,000	$650-$700
$29,001-$32,000	$725-$930
$32,001-$35,000	$960-$1,020
$35,001-$38,000	$1,050-$1,110
$38,001-$41,000	$1,140-$1,200
$41,001-$44,000	$1,230-$1,290
$44,001-$47,000	$1,320-$1,610
$47,001-$50,000	$1,645-$1,715
Over $50,000	Not Eligible

EPIC

EPIC is New York State's prescription plan for seniors. It provides 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.

Eligibility

- New York State residents aged 65 and older who are not receiving full Medicaid benefits and whose income is not higher than $35,000 if single or $50,000 if married, are eligible.

EPIC and Medicare Part D

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

Those with higher incomes must pay their Part D plan premiums. Therefore, to help seniors with incomes higher than $23,000 if single or $29,000 if married, EPIC will lower the deductible by $519.

EPIC Co-payments

Up to:	You pay:
$15	$3
$15.01-$35	$7
$35.01-$55	$15
$55.01 and over	$20

Please note, if you have any questions, call EPIC at 1-800-332-3742.

New York State and Medicare Working Together EPIC

Application

Please print clearly!

Who is applying? ☐ Yourself **only** ☐ Yourself **and your spouse**

Your Last Name **First** **Middle Initial**

c/o Name (if different from above)

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

City **State** **ZIP**

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

City **State** **ZIP**

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**

☐ **Married, Living Separately**

Spouse's Name (If Living)

Last Name **First** **Middle Initial**

Spouse's Social Security

Spouse's Date of Birth

Month **Day** **Year**

/ /

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

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

(Please turn over and fill in other side)

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