

**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.
- Fill in each line.
- Report all income including Social Security (less Medicare premiums) paid to you by check or direct deposit, pensions, interest from savings, IRA distributions, wages, etc. Multiply monthly amounts by 12 to get yearly income.
- To help us process your application faster, please provide copies of documents that verify your income if available.

	YOUR YEARLY INCOME	SPOUSE'S YEARLY INCOME
<b>1. Social Security and/or Railroad Retirement Benefits, (less Medicare premiums) paid to you by check or direct deposit</b>	\$ _____	\$ _____
<b>2. Pensions and Annuities</b>	\$ _____	\$ _____
<b>3. Other Income: Include IRA Distributions, Capital Gains, Wages, Business Income or Losses, Net Rental Income, etc.</b>	\$ _____	\$ _____
<b>4. Interest and Dividends</b>	\$ _____	\$ _____
<b>5. TOTAL YEARLY INCOME (Add lines 1-4)</b>	\$ _____	\$ _____

**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 may be required to give proof of my age, income, residency, Medicare status and other prescription insurance. I am required to enroll in a Medicare Part D drug plan, if eligible. 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 between EPIC and the Social Security Administration, Medicare, NYS Medicaid Program, NYS Tax Department, private insurance companies and other entities necessary. In the event of duplicate or overpayment by EPIC, I assign to EPIC any drug benefits that I may be entitled to under any other private insurance 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:**

_____	_____
<b>Your signature (legal representative)</b>	<b>Date</b>
_____	_____
<b>Spouse's signature (legal representative)</b>	<b>Date</b>

**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 form with proof of age, copy of your Medicare card if you have one, and income documentation if available to: EPIC, P.O. Box 15018, Albany, NY 12212-5018**

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



# Senior Alert!

## EPIC

**Important changes to EPIC effective:**  
*July 1, 2011 and Jan. 1, 2012*

Assemblymember  
 Vivian E. Cook

Dear Friend,

The 2011-2012 budget has made significant changes to the Elderly Pharmaceutical Insurance Coverage program (EPIC). EPIC has served as the state's prescription plan for seniors aged 65 and older who have incomes of \$35,000 or less if they are single, or \$50,000 or less if they are married.

Beginning July 1, 2011, EPIC, which provides assistance for Medicare Part D Prescription Drug Plan premiums for its Fee Plan participants, will extend this assistance for low-income Deductible Plan participants who have an annual income less than or equal to \$23,000 if they are single, and \$29,000 if they are married. This assistance will be paid directly to Medicare Part D. All participants will be responsible for any additional amount to pay the premium in full.

Beginning Jan. 1, 2012, the Fee and Deductible plans will be replaced by one level of coverage that is described on the reverse and will no longer be considered creditable coverage under Medicare Part D. If you don't choose to enroll in a Medicare Part D plan and you don't have creditable coverage under another plan, you will be penalized if you choose to enroll in a Medicare Part D plan at a later date. "Creditable coverage" is coverage that pays on average at least as much as the standard Medicare Part D plan.

Additional details of EPIC changes are provided in this brochure or can be obtained by calling the EPIC hotline, also listed.

Sincerely,

Vivian E. Cook  
 Member of Assembly

142-15 Rockaway Boulevard • Jamaica, NY 11436 • 718-322-3975

Room 939, LOB • Albany, NY 12248 • 518-455-4203

cookv@assembly.state.ny.us

## EPIC currently has two plans:

### 1. FEE PLAN

Participants pay an annual fee to receive EPIC coverage based on the participants' income and can be paid in convenient quarterly payments.

### 2. DEDUCTIBLE PLAN

There is no fee to join this plan. Instead, you pay full price for your prescriptions until you reach your deductible, which is based on your income. EPIC keeps track of how much you spend. You don't have to save receipts. After you reach your deductible, you save more than half for the rest of the year.

**Important: The Fee Plan and Deductible Plan will be replaced by one level of coverage, effective January 1, 2012.**

## EPIC change, effective July 1, 2011

Beginning July 1, EPIC will provide assistance with Medicare Part D premiums only for participants with annual incomes less than or equal to \$23,000 if single and \$29,000 if married.

## EPIC changes, effective Jan. 1, 2012

- EPIC will no longer be considered "creditable coverage" under Medicare Part D. "Creditable coverage" is coverage that pays on average at least as much as the standard Medicare Part D plan.
- In order for you to remain in EPIC, you will be required to enroll in a Medicare Part D plan **without exception by December 31, 2011, or be removed from the program.** EPIC will facilitate enrollment in Medicare Part D.
- EPIC will provide assistance with prescription drugs **only** during the coverage gap, called the "donut hole" phase of Medicare Part D, and only for drugs on participants' Part D plan formulary. There are certain narrow exceptions.
- **EPIC will only have one level of coverage for all participants, instead of the current Fee Plan and Deductible Plan.**
- Income eligibility will remain \$35,000 or less for single participants and \$50,000 or less for married participants.
- There will be no registration fees or deductibles for EPIC coverage and no annual limits on copayments.

## Please call the EPIC hotline for additional questions:

### EPIC Hotline

800-332-3742  
TTY -800-290-9138  
epic@health.state.ny.us

### Senior Hotline

800-342-9871

### NYS Department of Health

www.health.state.ny.us,  
scroll to "EPIC for Seniors"

**PLEASE NOTE: The EPIC application and hotline number in this brochure will remain in effect until December 31, 2011.**



# APPLICATION

FILL OUT THIS FORM COMPLETELY



**PLEASE PRINT CLEARLY**

Who is applying?  Yourself only or  Yourself and your spouse

Your Last Name First Middle Initial

c/o Name (If Different From Above)

Address Where You Live (Not P.O. Address)

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

**Telephone Number**

Area Code Number

( )

**Marital Status**

- Widowed, Single or Divorced  
 Married  
 Married, Living Separately

**Ethnic Information (Optional)**

- White  Black  Hispanic  
 Asian  Native American  
 Other

**Spouse's Last Name (If Living) First Middle Initial Social Security Number**

**Spouse's Date of Birth**

Month Day Year

**Spouse's Ethnic Information (Optional)**

- White  Black  Hispanic  Asian  
 Native American  Other

Are you enrolled in **MEDICARE** Part A or Part B?  Yes  No

If yes, enter Medicare Claim Number

Is your spouse enrolled in **MEDICARE** Part A or Part B?  Yes  No

If yes, enter spouse's Medicare Claim Number

Do you have **MEDICAID?** (Not Medicare)  Yes  No

If yes, enter Medicaid ID Number

If yes, do you have a Medicaid **spenddown?**  Yes  No

Does your spouse have **MEDICAID?**  Yes  No

If yes, enter spouse's Medicaid ID Number

If yes, does your spouse have a Medicaid **spenddown?**  Yes  No

(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**