



**PLEASE PRINT CLEARLY**

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

Your Last Name First Middle Initial

Social Security Number

c/o Name (If Different From Above)

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|

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

Sex

Female  Male

City State ZIP

Your Date of Birth

Month Day Year

Address Where You Get Your Mail (If Different From Above)

\_\_\_\_/\_\_\_\_/\_\_\_\_

City State ZIP

Telephone Number

Area Code Number  
( )

Marital Status

Ethnic Information (Optional)

- Widowed, Single or Divorced
- Married
- Married, Living Separately

- White  Black  Hispanic
- Asian  Native American
- Other

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

\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|\_\_\_\_\_|

Spouse's Date of Birth

Spouse's Ethnic Information (Optional)

Month Day Year

- 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**

**MARRIED**

**SINGLE**

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

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

## 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.

<b>1. Social Security and/or Railroad Retirement Benefits, (less Medicare premiums) paid to you by check or direct deposit</b>	<b>YOUR YEARLY INCOME</b>	<b>SPOUSE'S YEARLY INCOME</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:

_____ Your signature (legal representative)	_____ Date
_____ Spouse's signature (legal representative)	_____ 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 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.

NON DOH-3409

3/09

## DEDUCTIBLE SCHEDULE

Annual Income	Annual Deductible	Joint Annual Income	Annual Deductible (Each Person)
Under \$20,000	See Fee Plan	Under \$26,000	See Fee Plan
\$20,001 – \$21,000	\$530	\$26,001 – \$27,000	\$650
\$21,001 – \$22,000	\$550	\$27,001 – \$28,000	\$675
\$22,001 – \$23,000	\$580	\$28,001 – \$29,000	\$700
\$23,001 – \$24,000	\$720	\$29,001 – \$30,000	\$725
\$24,001 – \$25,000	\$750	\$30,001 – \$31,000	\$900
\$25,001 – \$26,000	\$780	\$31,001 – \$32,000	\$930
\$26,001 – \$27,000	\$810	\$32,001 – \$33,000	\$960
\$27,001 – \$28,000	\$840	\$33,001 – \$34,000	\$990
\$28,001 – \$29,000	\$870	\$34,001 – \$35,000	\$1,020
\$29,001 – \$30,000	\$900	\$35,001 – \$36,000	\$1,050
\$30,001 – \$31,000	\$930	\$36,001 – \$37,000	\$1,080
\$31,001 – \$32,000	\$960	\$37,001 – \$38,000	\$1,110
\$32,001 – \$33,000	\$1,160	\$38,001 – \$39,000	\$1,140
\$33,001 – \$34,000	\$1,190	\$39,001 – \$40,000	\$1,170
\$34,001 – \$35,000	\$1,230	\$40,001 – \$41,000	\$1,200
Over \$35,000	Not Eligible	\$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
		Over \$50,000	Not Eligible

SINGLE

MARRIED