



What is EPIC?

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program that provides seniors with co-pay assistance for Medicare Part D covered prescription drugs while members are in their coverage gap (donut hole). EPIC also covers the Medicare Part D excluded drugs purchased in the coverage gap. EPIC co-payments are \$3-\$20 depending on the cost of the drug.

The program is free – there are no fees or deductibles. And, EPIC pays Medicare Part D plan premiums, up to the amount of a basic plan, for members with annual income up to \$23,000 if single and \$29,000 if married. Those with higher incomes must pay their Part D plan premiums.

Who can join?

- a resident of New York State 65 or older with annual income up to \$35,000 if single or \$50,000 if married, and
- an eligible senior with a Medicaid spend down not receiving full Medicaid benefits

Medicare Part D Enrollment

Applicants may apply for EPIC before they are enrolled in a Medicare Part D plan, but all EPIC members must have Part D in order to receive EPIC benefits. Because EPIC is a qualified state pharmaceutical assistance program (SPAP), members are able to join a Part D plan during the year once enrolled in EPIC or have an opportunity to switch Medicare Part D plans one time during the year.

How to Apply

- Fill out the application completely and sign it.
- If you are married, you and your spouse can both use the same form.
- If married and living together, both must sign the form.
- Fill in your total income for the previous calendar year.
- If you are married and living together, report the total income for both you and your spouse even if only one person is applying.

For more information call the toll-free EPIC Helpline at **1-800-332-3742 (TTY 1-800-290-9138)**
Download an application in English or Spanish at: <http://health.ny.gov> *Click on EPIC for Seniors*
Or write:

EPIC

P.O. Box 15018

Albany, New York 12212-5018



Application



Please print clearly!

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

Your Last Name First Middle Initial

Social Security Number

____ | ____ | ____ | ____ | ____ | ____

c/o Name (if different from above)

Sex

Female Male

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

Your Date of Birth

Month Day Year
____ / ____ / ____

City State ZIP

Your Telephone Number

Area Code Number
()

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

Marital Status

Widowed, Single or Divorced
 Married
 Married, Living Separately

City State ZIP

Spouse's Name (If Living)

Spouse's Social Security Number

Last Name First Middle Initial

____ | ____ | ____ | ____ | ____ | ____

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 fill in Page 2)

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



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