

INCOME INFORMATION

Please use total income from the last calendar year, unless this year's income is lower. Please list ALL of the annual income received for applicant and spouse (if applicable) and provide photocopies of all income sources. For married couples, please fill in a social security amount for yourself and spouse. If your spouse does not receive social security, enter zero.

	SELF	SPOUSE (if applicable)
Adjusted Gross Income (Federal Tax Return)	\$	\$
Social Security (minus Part B premiums), Supplemental Security Income and/or Rail Road Retirement	\$	\$
Pensions, Retirement Income, Annuities, and/or Veteran's Benefits	\$	\$
Interest and/or Dividends	\$	\$
Other Income (Wages, Net Rental Income, Non-Taxable, etc.)	\$	\$
ANNUAL TOTAL	\$	\$

LOW INCOME SUBSIDY – EXTRA HELP INFORMATION

Completing this section will help determine if you qualify for Extra Help with Medicare Part D. Please complete the statements below. **If you HAVE NOT yet applied for Extra Help**, you must answer the questions below. **Extra Help may still be available to you if you have dependent relatives who rely on you or your spouse to provide at least fifty-percent of their financial support**. To determine your assets, add your savings, investments, and real estate. Do not include your primary home, vehicles, burial plots, or personal possessions.

If you are currently receiving assistance on the Medicare Savings Program (MSP) you are automatically eligible for the Low Income Subsidy-Extra Help with your Medicare Part D benefits. If you are not currently on MSP, please apply for the Annual Extra Help with Medicare Part D if your income and assets are below the threshold amounts as indicated in Section 3 of the Renewal Instructions.

Please check **ONLY** one box in each section. (See Section 4 of Instructions)

	SINGLE	MARRIED (if applicable)
ASSET INFORMATION <i>(effective January 1)</i>	For Single, Divorced, Widowed, Separated Applicants the <u>individual</u> assets exceed \$12,510	For Married Applicants <u>combined</u> assets exceed \$25,010
	<input type="checkbox"/> YES (Stop!) <input type="checkbox"/> NO (Complete A, B, C below)	<input type="checkbox"/> YES (Stop!) <input type="checkbox"/> NO (Complete A, B, C below)
A. I have applied for Extra Help:	<input type="checkbox"/> YES (go to question B) <input type="checkbox"/> NO (go to question C)	<input type="checkbox"/> YES (go to question B) <input type="checkbox"/> NO (go to question C)
B. If YES, My Extra Help application was:	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> PENDING Please send a copy of the SSA letter	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> PENDING Please send a copy of the SSA letter
C. If NO, please contact the Social Security Administration:	Telephone: 1-800-772-1213 Telephone (TTY): 1-800-325-0778 Website: www.ssa.gov	Telephone: 1-800-772-1213 Telephone (TTY): 1-800-325-0778 Website: www.ssa.gov

CERTIFICATION and AUTHORIZATION

I certify that the information on this form is true, accurate, and complete. I understand that if I provide false, fraudulent, or misleading information, I face fines and penalties under State law. I authorize the Social Security Administration, banking institutions, private insurance companies, and others to release information necessary to determine my ConnPACE eligibility. I authorize the ConnPACE program to release information about me, if applicable, as necessary for receipt of ConnPACE benefits and Medicare Prescription Drug Benefits and for the administration of the ConnPACE program, as permissible by federal or state law. I further authorize any health care provider to release all medical records pertaining to prescriptions covered by ConnPACE to assure that the services paid for by ConnPACE were appropriate. Social Security Number disclosure is required for the ConnPACE program under authority granted in 42 U.S.C. Section 405.

APPLICANT SIGNATURE / MARK _____ DATE _____

SPOUSE SIGNATURE / MARK _____ DATE _____

*** After completing all sections please SIGN AND DATE THIS APPLICATION ***

AUTHORIZED REPRESENTATIVE / POWER OF ATTORNEY / CONSERVATOR CONTACT INFORMATION

If the applicant is unable to sign for themselves, please attach proof of relationship as the Authorized Representative, Power of Attorney, or Conservator

NAME: _____ RELATIONSHIP: _____
 ADDRESS: _____ CITY / STATE / ZIP: _____
 TELEPHONE: (____) _____ - _____ FAX: (____) _____ - _____ E-MAIL: _____

FOR OFFICE USE ONLY				INCOME YEAR _____				CLERK # _____			
SELF				SPOUSE (if applicable)							
SIGNATURE	TOWN CODE _____			SIGNATURE	TOWN CODE _____						
AGE	Y	N		AGE	Y	N					
RES	Y	N	PDP	RES	Y	N	PDP				
INC	Y	N	TPL	INC	Y	N	TPL				
DIS	Y	N	S	DIS	Y	N	S				