

3. ADDRESS:

Mailing Address

Street or P.O. Box Number

City Zip Code

Home Phone Number - -

Area Code Prefix Number

4. ALTERNATE ADDRESS: If you reside elsewhere during the year.

Dates: From to

Mailing Address

Street or P.O. Box Number

City Zip Code

Phone Number - -

Area Code Prefix Number

5. ADDITIONAL CONTACT (optional): If you prefer we contact someone else if we have additional questions, please provide his or her information. By listing this person it gives us your permission to share your Big Sky Rx program information with them.

First Name:

Last Name:

Mailing Address

Street or P.O. Box Number

City Zip Code

Home Phone Number - -

Area Code Prefix Number

WHO DO YOU WANT US TO SEND NOTICES AND FOLLOW-UP INFORMATION TO?

Applicant Only Contact Only Both Applicant **AND** Contact

6. ARE YOU A MEMBER OF A TRIBE (optional):

Applicant No Yes Tribe Name

Spouse No Yes Tribe Name

7. IN THE PAST 12 MONTHS, have you or your spouse received **MEDICAID** benefits from Montana or any other state?
 No Yes State

8. ADDITIONAL FAMILY MEMBERS: How many relatives live with you and/or your spouse **and** depend on you or your spouse to provide at least one-half of their financial support. Relatives include anyone related to you by blood, marriage or adoption. **DO NOT include yourself or your spouse in this number. Check only one box.**

0 1 2 3 4 5 6 7 8 9

9. MONTHLY FAMILY INCOME: If you and/or your spouse, (if married and living together) receive income from any of the sources listed below, please enter the **total MONTHLY GROSS income for each person (total before taxes).** If the amount changes from month to month, enter the **average monthly income for the past year for each type. DO NOT** list income tax refunds, wages and self-employment, interest income, public assistance, medical reimbursements, or foster care payments here.

	GROSS MONTHLY	
	Applicant	Spouse
Social Security Benefits	<input type="checkbox"/> None \$	\$
Railroad Retirement	<input type="checkbox"/> None \$	\$
Veterans Benefits	<input type="checkbox"/> None \$	\$
Net Rental Income	<input type="checkbox"/> None \$	\$

10. OTHER UNEARNED INCOME: List the **MONTHLY** amount in the space(s) below. Examples include: Public or Private Pensions, Annuities, Worker's Compensation, Dividends, Interest, Alimony, Income from a Trust, Inheritances. **DO NOT list income reported in question 9.**

<input type="checkbox"/> NONE	Applicant	Spouse
Source of Income:	\$	\$
Source of Income:	\$	\$

11. WAGES/EARNED INCOME: What wages do you expect to earn before taxes this year? Include wages, tips, net earnings from self-employment, royalties and honoraria. **If none, skip to question 12. DO NOT list income reported in question 9 and 10.**

	YEARLY	
Applicant	<input type="checkbox"/> None	\$
Your Spouse	<input type="checkbox"/> None	\$

WORK RELATED DISABILITY OR BLINDNESS EXPENSE: Do you and/or your spouse, (if married and living together) have to pay for adaptive items that enable you to work **for which you are not reimbursed?**

Legally Disabled	Applicant	No <input type="checkbox"/> Yes <input type="checkbox"/>	Spouse	No <input type="checkbox"/> Yes <input type="checkbox"/>
Legally Blind	Applicant	No <input type="checkbox"/> Yes <input type="checkbox"/>	Spouse	No <input type="checkbox"/> Yes <input type="checkbox"/>

12. FAMILY ASSETS: This information is used to determine potential eligibility for the Federal program, Social Security Extra Help. **We will notify you if your income and assets indicate you must apply for Social Security Extra Help.** Extra Help can pay for Medicare prescription drug plan co-payments, deductibles, and premiums.

Single	<input type="checkbox"/> Less than \$13,640	<input type="checkbox"/> More than \$13,640
Married	<input type="checkbox"/> Less than \$27,250	<input type="checkbox"/> More than \$27,250

Assets are defined as: Total value of any financial institution accounts (including checking, savings, certificates of deposit, retirement accounts, such as Individual Retirement Accounts (IRA), 401(k) accounts and similar items), stocks, bonds, savings bonds, mutual fund shares, or other similar investments, cash, any other real estate other than your home and the property on which it is located and investments. Include the things you own by yourself, with your spouse or with someone else. **DO NOT include your home, vehicles, burial plots or personal possessions.**

13. HAVE YOU APPLIED FOR SOCIAL SECURITY EXTRA HELP?

No Yes

If yes, what was your determination? Check only one box and include a copy of your determination.

Applicant	<input type="checkbox"/>					
	Still In Progress	Denied	25%	50%	75%	100%
Spouse	<input type="checkbox"/>					
	Still In Progress	Denied	25%	50%	75%	100%

14. MEDICARE PRESCRIPTION DRUG PLAN:

Have you enrolled with a Medicare prescription drug plan? Even if you have not yet signed up for a Medicare prescription drug plan, complete this application and mail it to Big Sky Rx. When we receive your prescription drug plan information, we will enroll you into Big Sky if you qualify

	Plan Name	
Applicant	No <input type="checkbox"/>	
Spouse	No <input type="checkbox"/>	
	Premium Amount	Effective Date
Applicant	\$	
Spouse	\$	