Big Sky Rx Program Application

Please fill out only one application, but answer the questions separately for you and your spouse if you are married and living together. Please print. Use capital letters. It is IMPORTANT that you fill in all sections. Missing information will cause delays.

SEND IN YOUR:
- ✓ Big Sky Rx Application
- ✓ Copy of Enrollment Information (Medicare Prescription Drug Plan)
- ✓ Copy of Your Extra Help Determination (if applicable)

SEND TO: Big Sky Rx Program
PO Box 202915
Helena, MT 59620-2915

CONTACT US AT:		
	1-866-369-1233	Toll Free from In State
	1-406-444-1233	Out of State and Helena
	1-406-444-3846	Fax
	711	MT Relay Service
	Bigskyrx@mt.gov	Email
	www.bigskyrx.mt.gov	Web Site

ADA - Persons with disabilities who need an alternative accessible format of this information, or who require some other reasonable accommodations in order to participate in Big Sky Rx, should contact us at the numbers above.

1. APPLICANT:

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Suffix ☐☐

Are you applying for Big Sky Rx? ☐ Yes ☐ No ☐ Already enrolled

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Medicare Effective Date: Month ☐☐ Year ☐☐☐☐

Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐ Gender: ☐ Male ☐ Female

2. SPOUSE: (if married and living together):

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Middle Initial ☐

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Suffix ☐☐

Are you applying for Big Sky Rx? ☐ Yes ☐ No ☐ Already enrolled

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Medicare Effective Date: Month ☐☐ Year ☐☐☐☐

Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐ Gender: ☐ Male ☐ Female

3. ADDRESS:

Mailing Address

Street or P.O. Box Number

City Zip Code

Home Phone Number - -

Area Code Prefix Number

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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

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
Social Security Benefits	☐ **None**	**$**
Railroad Retirement	☐ **None**	**$**
Veterans Benefits	☐ **None**	**$**
Net Rental Income	☐ **None**	**$**

10. **OTHER UNEARNED INCOME:** Please 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.

		MONTHLY
Source of Income:	☐ **None**	**$**
Source of Income:	☐ **None**	**$**

11. **EARNED/WAGES INCOMES:** What do you expect to earn in wages 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 questions 9 or 10.**

		YEARLY
Applicant	☐ **None**	**$**
Your Spouse:	☐ **None**	**$**

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

Legally Disabled	**Applicant**	**No** ☐	**Yes** ☐	**Legally Blind**	**Applicant**	**No** ☐	**Yes** ☐
	Spouse	**No** ☐	**Yes** ☐		**Spouse**	**No** ☐	**Yes** ☐

12. **FAMILY ASSETS:** This information is used to determine potential eligibility for the Federal program, **Social Security Extra Help.** Extra Help can pay for Medicare prescription drug plan co-payments, deductibles, and premiums. We will notify you if your income and assets indicate you must apply. **Assets are not counted for the Big Sky Rx Program.**

Single	☐ **Less than $17,220**	☐ **More than $17,220**
Married	☐ **Less than $34,360**	☐ **More than $34,360**

Assets are defined:
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, and any other real estate other than your home and the property on which it is located, investments and real estate (other than your home). 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.

	☐ Still In Progress	☐ Denied	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Spouse	☐ Still In Progress	☐ Denied	☐ 25%	☐ 50%	☐ 75%	☐ 100%

14. MEDICARE PRESCRIPTION DRUG PLAN:
Have you enrolled with a Medicare prescription drug plan?
What is your Medicare drug coverage plan name option or choice?

			Plan Name	Premium Amt	Effective Date
No	☐	**Applicant**			
No	☐	**Spouse**			

If you have not yet signed up for a Medicare prescription drug plan, please continue to fill out this application and mail it to Big Sky Rx. When we receive your prescription drug plan information, we will enroll you into Big Sky Rx, if you qualify.

15. PAYMENT METHOD:

Self	**Your Spouse**	
☐	☐ (if living together and applying for Big Sky Rx.)	**Pay Plan -** Check here if you want Big Sky Rx to pay your premium directly to your prescription drug plan. **If you reside elsewhere during the year, check this payment method.** Note: Some plans cannot accept direct payment from Big Sky Rx. Big Sky Rx will notify you if another payment method choice is needed. **DO NOT check if your Part D premium is taken out of your Social Security check or checking account.**

If your Part D premium is taken out of your social security check or checking account, select one of the options below:

Self	**Your Spouse**	
☐	☐ (if living together and applying for Big Sky Rx.)	**Direct Deposit -** Check here if you want the monthly premium amount from Big Sky Rx directly deposited to your bank account. Big Sky Rx will send you the direct deposit forms to complete. **You are responsible to pay your premium to your plan.**

NOTE: Your enrollment starts the first day of the month following receipt of all requested information.

16. MY SIGNATURE ON THIS APPLICATION INDICATES: I understand that by submitting this application, I am declaring under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime. I know I must provide any documentation related to this application if requested. Failure to do so will result in ineligibility or closure of benefits. I understand that the Big Sky Rx Program may check my statements and compare my records from Federal, State, and local government agencies, with my application to make sure the determination is correct. By submitting this application, I am authorizing Big Sky Rx to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, insurance policies, benefits, and pensions. If I knowingly give false information to enroll in Big Sky Rx, I understand that I must reimburse Big Sky Rx for any costs incurred. If an audit proves I am over income, I know I will be disenrolled as of the following month from Big Sky Rx. **If I change my address, am no longer a Montana resident, change Medicare Prescription Drug Plans or have a change in Extra Help (if applicable), I must report the change to Big Sky Rx within 20 business days. ALL APPLICANTS MUST SIGN.**

Signature of Applicant _____

Date _____

Signature of Spouse (if applying for Big Sky Rx) _____

Date _____

Signature of Representative (if applicable) _____

Date _____

Confidentiality Statement

Your name, address, social security number and/or other identifying information provided on this application is confidential and will only be used by Big Sky Rx for the sole purpose of the administration of this program.

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