

What is NYP\$?

NYP\$ is a free pharmacy discount card that is sponsored by New York State. You can use this card at participating pharmacies to save as much as 60% on generics and 30% on brand name drugs. The savings are provided through the cooperation and support of local pharmacies and drug manufacturers.

How to Apply for the NY Prescription Saver Card

To be eligible, each applicant must be:

- a resident of New York State;
- not receiving Medicaid;
- either (a) age 50 up to 65, or (b) determined disabled by the Social Security Administration **AND**
- have annual income under \$35,000 if single and \$50,000 if married.

To apply, complete the application on the back following the instructions below, and send to NYP\$ using the mailing address or website shown on the bottom of the application.

1 Personal Information

Each person applying needs to fill out a separate application. If you have a spouse or another family member who is applying, they should complete a separate application. Each applicant that is approved will receive his or her own pharmacy discount card. Fill in the full name of the applicant, and the mailing address for correspondence.

Enter the name of another person who would be receiving the mail for the applicant as a C/O name.

Enter the birth date of the applicant (MM, DD, YYYY), as well as sex and marital status (S=single, unmarried, divorced, widowed or married living apart, M=married).

Enter the race of the applicant (optional).



2 Disability status

Check **YES** under “Disability Status” only if the applicant has been determined disabled by the Social Security Administration. Otherwise check **NO**.

3 Household Income

Report the total household gross income for the previous calendar year. If you are married and living together, include joint income, even if your spouse is not applying. Include income from wages, IRA distribution, dividends and interest, Social Security, railroad pensions, Workers Compensation, Veterans benefits and other income.

4 Certification and Consent

Read the certification statement carefully, and sign the application form. If the applicant is unable to understand or sign the form, an authorized representative may sign their name on behalf of the applicant.

Mail to:

New York Prescription Saver
P.O. Box 12069
Albany, New York 12212-2069

or apply online.

Questions?

Visit our website:

<http://nyprescriptionsaver.fhsc.com>

or call us:

1-800-788-6917 (TTY 1-800-290-9138)

**Buy your drugs
at a discount!**

Use the

New York Prescription Saver Card



Sponsored by
New York State

Application for New York Prescription Saver Card

Please note you may also apply online.
Go to <http://nyprescriptionsaver.fhsc.com>



Please print carefully

1 Personal Information

First Name _____ Middle Initial _____ Last Name _____

Street Address _____ P.O. Box or Apt. # _____

City _____ State _____ ZIP _____

C/O Name (if different from above): _____

Birthdate
MM/DD/YYYY

Sex
M/F

Marital Status
S/M

Ethnic Origin (Optional)

Telephone - -

S = single, unmarried, divorced,
widowed or married living apart
M = married

B = Black I = American Indian/Alaskan
A = Asian H = Hispanic
W = White O = Other

2 Disability Status

If you have been determined disabled by the Social Security Administration, check **YES** under "Disability Status." Otherwise check **NO**.

Disability Status: Yes No

3 Household Income

Report below the **total household gross income** earned during the last calendar year by you (if single) or you and your spouse (if married). Report joint income even if only one spouse is applying. Include salaries and wages, dividends and interest, Social Security, pensions, and other income: See instructions for details.

Annual Income Last Year. \$ _____

4 Certification and Consent

I certify that the information on this form is correct and true. I reside in New York State, and am not currently receiving Medicaid benefits. I agree to provide proof of age, income, disability, and residency and other identification information if required by NY Prescription Saver. I consent to the exchange of all information necessary to verify my eligibility between NY Prescription Saver and the Social Security Administration, NYS Medicaid Program, the NYS Tax Department and others. I authorize my health care providers to release information about my prescriptions to be used for authorized program purposes.

You (or your legal representative) must sign below:

Your Signature _____ Date _____

Mail this form to: **NYP\$**
P.O. Box 12069
Albany, New York 12212-2069