RETIREMENT HEALTH CARE FOR HARDSHIP PRESCRIPTION CO-PAYMENTS APPLICATION

COUNTY OF ST. CLAIR

Effective August 1, 2012, the retirement health care hardship provision was amended to establish household total income to qualify in lieu of annual pension amount.

You may qualify for the St. Clair County Retirement health care hardship reduced prescription co-payment provision if your annual household income is $24,999.00 or less AND you retired with 20 or more years of eligible credited service.

The retirement health care for hardship prescription co-payment application on the reverse side must be completed and returned to:

St. Clair County – Human Resources
200 Grand River Avenue, Suite 206
Port Huron, Michigan 48060

on or before November 30th in order for verification of eligibility to be completed for the following year. Upon completion of the verification of eligibility, applicants will be notified by mail of their eligibility status. Approved hardship applicants will receive lowered prescription co-payments from January through December of the upcoming year. All others will receive the standard (non-hardship) retirement prescription co-payments.

The St. Clair County Retirement Hardship Prescription Co-payment application must be completed each year and submitted for verification of eligibility even if approved in the previous year.

The reverse side of this application must be completed and submitted with copies of the previous year's 1040 Federal Income Tax return including all attachments and schedules showing total income such as, by way of example, K-1's, 1099's, W-2 and any other information necessary to disclose the total income received by your household which includes any income received by a spouse during the tax year.

The failure to supply the information necessary to disclose all household income will result in disqualification from the hardship program.

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HARDSHIP PRESCRIPTION CO-PAYMENTS APPLICATION

Applicant (Person Receiving Retirement Benefit)					
Last Name		First Name		M/I	
Date of Birth		SSN			
Address 1		Address 2			
City		State		Zip Code	

Other (Spouse or Other Person Contributing to Household Income)					
Last Name		First Name		M/I	
Date of Birth		SSN			

Number of Individuals Living in household including students	
Number of Individuals Contributing to household income	

Income to Report – (include everyone in household)				
Type of Income	Applicant Monthly Amount	Spouse Monthly Amount	Others Monthly Amount	Total Monthly Amount
Wages/Salaries/Tips				
Strike Benefits				
Unemployment Compensation				
Workers' Compensation				
Net Income from Self-Owned				
Business				
Pensions				
Supplemental Security Income				
Retirement Income				
Veteran's Income				
Social Security				
Disability Benefits				
Interest/Dividends/Capital Gains				
Income from Estate/Trust/Investment				
Public Assistance Payments				
Welfare Payments				
Alimony/Child Support Payments				
Lottery				
Any Other Income				
Contributions from Persons Not Living in the Household				
TOTAL Monthly Amount				
Multiply the Total Monthly Amount by 12 months to obtain the **TOTAL ANNUAL HOUSEHOLD INCOME**				

*The information provided is confidential and will be used solely for the purpose of determining eligibility.

I certify (promise) that all information on this application is true and that all household income has been reported. I understand that I must provide supporting tax filing documents and that the information reported may be verified. I understand that if I purposely give false information, my application will be declined and I will not receive reduced prescription co-payments under the hardship provision.

Signature: X _____ **Print Name:** _____ **Date:** _____