



PACE^{PLUS} New Enrollment Application and Instructions

PACE^{PLUS} Will Work Together with Medicare Part D and Retiree Prescription Coverage!

PACE and PACENET offer Prescription Coverage For Older Pennsylvanians

PACE^{PLUS} also known as **PACE** and **PACENET** are the Commonwealth of Pennsylvania's prescription benefit plans that currently serve over **312,000** older Pennsylvanians.

PACE^{PLUS} will help reduce the cost of your prescription medications. You may even qualify for reduced copays under Medicare Part D.

You are Eligible to Apply if:

- You are 65 years of age and older. (You are not eligible for benefits if you are under the age of 65 and disabled.)
- You have been a resident of Pennsylvania for at least 90 (ninety) consecutive days prior to your application.
- You are not eligible for pharmaceutical benefits under Medicaid.

You can be enrolled in **PACE^{PLUS}** and other prescription plans. **PACE^{PLUS}** will wrap around your current Medicare Part D coverage.

PACE/PACENET now offers even better coverage with PACE^{PLUS} prescription benefits for Older Pennsylvanians.

You're Eligible if:

you are single and your total **income for last year** was less than **\$14,500**, or you are married and your combined **income for last year** was less than **\$17,700**. You may be eligible for prescription benefits that have no more than a **\$6** copayment for generic drugs and **\$9** copayment for brand name drugs. This copayment applies to each covered prescription that you have filled. **PACEPLUS** will pay your Medicare Part D premium for you.

If you are single and your total **income for last year** was between **\$14,500** and **\$23,500**, or you are married and your combined **income for last year** was between **\$17,700** and **\$31,500** you may be eligible for prescription benefits that have no more than an **\$8** copayment for generic drugs and **\$15** copayment for brand name drugs. You pay your monthly Medicare Part D premium each month directly to your Plan.

PACENET has a monthly **premium** if you are **not** enrolled in a Medicare Part D plan, which will be cumulative if not met each month. If you are not enrolled in a Medicare Part D plan, your monthly premium begins with your first prescription claim and the premium is paid at your pharmacy. **We encourage you to apply to a Medicare Part D plan.**

What is Considered Income?

Income includes, but is not limited to, the following:

Gross Social Security	Interest/Dividends/Capital Gains
Railroad Retirement & SSI	Net Rental Income
Pensions	Royalties
Salaries/Wages/Commissions	Workers' Compensation
Self-Employment or partnership income	Life insurance benefits
Alimony and Support money	Gifts and inheritance of cash or property over \$300
Taxable amount of annuities and IRAs	Any amount of money or fair market value of a prize, such as a car or trip won in a lottery, contest or gambling
Unemployment	
Veteran's disability payments	
Cash public assistance	

Assets are not used in determining your eligibility for PACEPLUS

You do not Need to Include Documentation

The **PACEPLUS** program verifies your age, income and residency upon application with the Social Security Administration, Railroad Retirement Board, State Employees Retirement System, Pennsylvania Department of Revenue, The Department of Labor and Industry and the Department of Transportation. You do not need to include documentation with this application. If you would like your Power of Attorney to receive all **PACEPLUS** correspondence, please include a complete copy of the Power of Attorney document and check the box in section F.

Understanding Age, Income and Residency Verification

It is important to carefully review the age, income and residency information that you report on your application. Be sure to include all income that you and your spouse (if married) received during the previous year. Do not include this year's income. At a later date, the program may request you to provide photocopies of your age, income and residency documents to verify the information you reported on your application.

If it is determined that you incorrectly reported your age, income or residency status and that you are ineligible to receive these benefits, you will be required to repay the program for any benefits it paid on your behalf.

Important Facts to Remember when Applying:

If you are married, but separated from your spouse during the past year or one of you lived in a nursing home, your marital status is "married living separately," and you should report only your income.

If widowed, you should report only your previous year's income. Do not include your spouse's income.

If you sold your home, all capital gains must be declared as income within two (2) years of the sale date.

If you sold your home to pay for nursing home costs or used those proceeds to purchase another residence deeded in your name, it is not considered income if proof is shown.

If you had income from the following sources, you do not have to report them on your application:

Black or White lung, property tax/rent rebate payments, damages received from civil suit or settlement agreement, benefits granted under Section 306C of Workers' Compensation Act, non-cash relief, food stamps, LIHEAP payments, gifts or inheritance totaling \$300 or less and the first \$10,000 in death benefits.

Certain AmeriCorps*VISTA payments may be excluded from income, pending review by the Department.

Aid & Attendance payments from the VA do not have to be counted as income if you can show proof that the payment is for A&A and proof of the actual A&A payment amount.

Instructions for Completing the PACE_{PLUS} Application

- If you are married and both of you are applying for benefits, you must check the box that you are filing for “Yourself and Your Spouse.” If you are the only one applying on this application, check the box that states “Yourself Only.”

- A. **Applicant:** Complete all information in this section. Include copies of all health insurance cards including Medicare Part D coverage. Your Medicare Claim Number is located on your Medicare Health Insurance Card.



- B. **Spouse:** If married, complete all information in this section. Include copies of all health insurance cards including Medicare Part D coverage. Your Medicare Claim Number is located on your Medicare Health Insurance Card.
- C. **Marital Status:** Circle the number that best describes your status. Include year separated or divorced.
- Residence:** Circle appropriate number.
- Ethnic Origin :** Circle appropriate number.
- D. List all income for last year (January through December). Include spouse’s income if married.
- E. Sign and date the application. Read the “**Certification and Authorization**” statements included with the application.
- F. Power of Attorney (POA) or Guardian can sign for applicant(s). Include POA documents. POA documents must include the name of the person who is giving the POA, the name of the person who is appointed as the POA, the signature of the person who is giving POA and the acknowledgement statement and signature of the person who is appointed POA.
- G. Witness/Preparer Signature is required if the applicant marks “x” in Signature.

Important Reminder:

PACE_{PLUS} may facilitate your enrollment into a Medicare Part D plan that best fits your prescription needs. We will review your Part D coverage annually.

PACE_{PLUS}



**Questions?
Call Cardholder Services**

**1-800-225-7223
Within Pennsylvania**

**717-651-3600
Outside Pennsylvania**

**Hearing Impaired Callers Using a TDD
(Telecommunication Device for the Deaf)**

**Should Call:
1-800-222-9004**

**717-651-3608
Application Fax Number**

Mailing Address For New Enrollment Application and Health Insurance Cards

**PACE
P.O. Box 8806
Harrisburg, PA 17105-8806**

**PACECares@fhsc.com
E-mail Address**

**Nora Dowd Eisenhower
Secretary of Aging**

**Edward G. Rendell
Governor**



CERTIFICATION AND AUTHORIZATION STATEMENTS

Please Read this Information Carefully

I understand that my signature on the application indicates my agreement to the following provisions:

- A. I authorize the Department of Aging, within its discretion, to release any and all information in my PACE file as deemed appropriate by the Department. I authorize such release of information.
- B. I authorize the Department of Aging to visit my residence with reasonable prior notice to me, for the purpose of determining the validity of information provided on the application or any claims made under the PACE program.
- C. I understand that PACE may provide general information of PACE participants to outside sources for research purposes, as deemed appropriate by the Department.
- D. I hereby assign to the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to drug benefits to which I may be entitled under any other plan of government assistance or insurance from any for-profit third party insurer.
- E. I hereby waive the confidentiality of any health care information found in any Medicare HMO Advantage plan, third party insurer's file or any other information from any health care source about my medications as witnessed by my signature on this application. I authorize such release of information for use consistent with this application. I understand that PACE may contact my physician for relevant medical history and information related to my prescription drugs paid for by PACE. I waive the confidentiality of such medical records and authorize their release to the PACE program.
- F. I agree to forgo any payment from any insurance company for any amount which has been paid by PACE on my behalf.
- G. I authorize the Internal Revenue Service, the Social Security Administration, the United States Railroad Retirement Board, the Pennsylvania Department of Revenue, the Pennsylvania Department of Transportation, the Pennsylvania Department of Labor and Industry, any other federal or state agency and any other financial or other institution or entity with information on my income or resources to release information to the PACE program that will verify my eligibility for the PACE program or for the low income subsidy of the federal Medicare prescription drug benefit. All information released to the Department of Aging shall remain confidential in accordance with 72 P.S. § 3761-517(b).
- H. I authorize the Department of Aging or its designee to act as my representative for determining my eligibility and applying for the low income subsidy of the Medicare prescription drug benefit, enrolling me in the Medicare prescription drug plan that best fits my prescription needs and, if I am a PACE enrollee, paying the premium of the selected Medicare prescription drug plan that is less than or equal to the regional benchmark premium.

Where the applicant(s) executed a Power of Attorney or is adjudicated incapacitated, the Department of Aging shall accept the Attorney-In-Fact or court-appointed Guardian as an authorized agent for the purpose of documenting enrollment. Power of Attorney or Guardianship documentation must be provided.

Need help in completing this application? Call PACE Cardholder Services:

1-800-225-7223
Within Pennsylvania

1-717-651-3600
Outside Pennsylvania

Mail or fax your completed application in the enclosed envelope to:
PACE/PACENET
P.O. Box 8806
Harrisburg, Pa 17105-8808

FAX
1-717-651-3608



PACE/PACENET
 P.O. Box 8806
 Harrisburg, PA 17105-8806



PACE/PACENET NEW ENROLLMENT APPLICATION

Enrolling For: Yourself Only (age 65 or older)
 Yourself & Your Spouse (age 65 or older)

A	Last Name	First Name	M/I	Gender M or F	Social Security #	Medicare Claim Number (HICN)
	Home Address		Apt #	Birth Date (Mo) (Day) (Year) / /		
	City	State	Zip	Home Phone ()	Driver's License Number	
B	Spouse's Last Name	First Name	M/I	Gender M or F	Spouse Social Security #	Medicare Claim Number (HICN)
	Spouse's Home Address (if different)		Apt #	Birth Date (Mo) (Day) (Year) / /		
	City	State	Zip	Home Phone ()	Driver's License Number	
C	Marital Status (Circle One) - Required		Residence Type (Circle One) - Required		Ethnic Origin (Circle One) - Optional	
	1 Single/Widowed 2 Married 3 Divorced _____ (List Year Divorced) 4 Married Living Separately _____ (List Year Separated)		<u>Applicant</u> 1 Own 2 Rent 3 Nursing Home 4 Personal Care Home 5 Live with Relative 6 Other		<u>Spouse</u> 1 Own 2 Rent 3 Nursing Home 4 Personal Care Home 5 Live with Relative 6 Other	
D LIST ALL INCOME FROM PREVIOUS YEAR (SINGLE APPLICANTS REPORT SINGLE INCOME. MARRIED COUPLES LIVING TOGETHER MUST REPORT COMBINED INCOME).						
Note: Please Refer to Brochure for Complete Instructions						
				Applicant	Spouse	Total
1	Total Previous Year's Gross Social Security -- Include Medicare Premiums and Supplemental Security Income (SSI)					1
2	Total Previous Year's Gross Railroad Retirement Benefits (RRB-1099 and RRB-1099R Form)					2
3	Total Previous Year's SERS Pension (State Employees Retirement)					3
4	Total Previous Year's Gross Pensions (not listed in 2 & 3 above), and Taxable Amount of Annuities and IRAs					4
5	Total Previous Year's Interest, Dividends, Capital Gains and Prizes					5
6	Wages, Salary, Bonuses, Commissions, Self-employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony, Support, Gifts and Inheritance over \$300, & Death Benefits over \$10,000					6
7	TOTAL ANNUAL INCOME (Add Lines 1 Through 6)					7
By signing, I acknowledge that I have read the certification and authorization on the back of this application and agree to the terms as stated, and that I have lived in Pennsylvania for at least 90 days prior to the date of this application, and that the age and income information listed is true, correct and complete.						
E	Applicant or Power of Attorney (POA) Signature			Spouse (If Applying) or Power of Attorney (POA) Signature		
	Date ____/____/____			Date ____/____/____		
F	Check box to send all correspondence to POA <input type="checkbox"/>			Check box to send all correspondence to Spouse POA <input type="checkbox"/>		
	Copy of Durable POA Document is Required if POA Signs Application			Copy of Durable POA Document is Required if POA Signs Application		
	Name			Name		
	Address			Address		
City			City			
State			State			
ZIP			ZIP			
Phone #			Phone #			
G	Witness/Preparer's Signature (If not the Applicant)			Witness/Preparer's Signature (If not the Applicant)		
	Phone #			Phone #		
Date ____/____/____			Date ____/____/____			

Your Survey on Health and Well-Being

Gender: ___ Male ___ Female

Social Security Number

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We would appreciate it if you would answer the following questions about your current health and well-being. (Even if you have completed a similar survey in the past, it is important to complete the present survey because many of the questions have changed.) However, you are under no obligation to complete the survey, nor will your decision in any way affect your eligibility for enrollment in PACE/PACENET. All information is confidential and will be used only for research about the health needs of people who enroll in PACE/PACENET. Your answers are important in helping us to improve upon the delivery of health services and benefits for older Pennsylvanians.

- Would you say that in general your health is:
 1. Excellent 2. Very good 3. Good 4. Fair 5. Poor
- Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
_____ days (If none, enter zero on the line.)
- Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
_____ days (If none, enter zero on the line.)
- During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
_____ days (If none, enter zero on the line.)
- During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?
_____ days (If none, enter zero on the line.)
- Do you have any problems reading or understanding instructions about your medications that you receive from your physician or pharmacist?
 1. No, I have no problems reading and understanding instructions about my medications.
 2. Yes, sometimes I do have problems.
If yes, what kind of problems do you have? Please check all that apply.
 a. Vision problems (for example, reading small print).
 b. Problems in reading (for example, understanding words).
 c. Problems because English is not my native language.
 d. Other problems (please describe briefly) _____
- Is there a friend or family member that could help you read and understand labels on medicine containers, and the instructions from the physician or pharmacist, if needed?
 1. Yes 2. No 3. Not Sure
- During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?
 a. None b. 1 time c. 2 times d. 3-5 times e. 6-9 times f. 10 or more times

PLEASE TURN THE PAGE OVER AND CONTINUE

9. During the last 12 months, have you done any of the following:
- a. Skipped doses of a medicine to make the prescription last longer? 1. Yes, often 2. Yes, sometimes 3. No, never
- b. Spent less on food, heat, or other basic needs so that you would have enough money for your medicines? 1. Yes, often 2. Yes, sometimes 3. No, never
- c. Had a family member or friend who helped pay for your medicine? 1. Yes, often 2. Yes, sometimes 3. No, never
- d. Gotten samples of a prescription for free from a doctor? 1. Yes, often 2. Yes, sometimes 3. No, never
10. During the last 12 months, was there any time you avoided seeing a doctor because of concerns about the cost of prescription drugs? 1. Yes 2. No 3. Not Sure
11. Are you LIMITED in any way in any activities because of any impairment or health problem? 1. Yes 2. No.
12. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house? 1. Yes 2. No
13. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? 1. Yes 2. No
14. What is your approximate height and weight? Height: ___ ft ___ in Weight: _____ pounds
15. What is your educational level? Please give highest grade completed. _____

The next few questions ask about experiences you may have had with a Medicare prescription drug plan. You can be enrolled in a Medicare prescription drug plan and also be enrolled in PACE/PACENET. (Your answers will not affect either your Medicare benefit or your PACE/PACENET benefit in any way.)

16. Have you ever been enrolled in a Medicare prescription drug plan? 1. Yes 2. No
- If yes, are you still enrolled? 1. Yes 2. No 3. Not Sure

The following are some statements that may or may not describe your feelings about the Medicare prescription drug plan you are (or were) most recently enrolled in. For each statement, please indicate how strongly you agree or disagree with the statement.

- | | Strongly Agree | Somewhat Agree | Somewhat Disagree | Strongly Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| a. My monthly plan premium was affordable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My annual deductible was reasonable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My co-pays were affordable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My total out-of-pocket costs were reasonable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My plan covered all the medicines my doctor prescribed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My plan was convenient to use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I understood how my plan worked and how to use it | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

THANK YOU. YOUR ANSWERS WILL HELP US TO IMPROVE THE DELIVERY OF HEALTH CARE SERVICES AND BENEFITS FOR OLDER PENNSYLVANIANS.

Spouse's Survey on Health and Well-Being If Spouse is Also Applying for PACE/PACENET

Social Security Number

Gender: Male Female

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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13. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? 1. Yes 2. No
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- | | Strongly Agree | Somewhat Agree | Somewhat Disagree | Strongly Disagree |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
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| b. My annual deductible was reasonable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| d. My total out-of-pocket costs were reasonable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My plan covered all the medicines my doctor prescribed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. My plan was convenient to use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I understood how my plan worked and how to use it | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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