



New Enrollment Application



PACE/PACENET

Prescription Coverage For Older Pennsylvanians

Prescription Benefits for Older Pennsylvanians

PACE and **PACENET** are the Commonwealth of Pennsylvania's prescription benefit plans that currently serve over **225,000** older Pennsylvanians.

- On December 31, 2003 the PACE/PACENET Moratorium expired. At one time, applicants were eligible to remain in the program if the only reason their total income exceeded the Program's income limits was due to their cost-of-living adjustment from Social Security. This policy no longer exists and will not be offered to any individuals who apply for benefits in 2004.

Have Questions or Need Assistance? Call us Toll Free at
1-800-225-7223 (in PA)
717-651-3600 (outside PA)

Who Is Eligible to Apply?

- Residents of **Pennsylvania** who are 65 years of age and older. You are not eligible for benefits if you are under the age of 65 and disabled.
- Must have been a resident of Pennsylvania for at least 90 (ninety) days prior to application.
- You are not eligible for pharmaceutical benefits under Medical Assistance.

You can apply for [PACE/PACENET](#) even if you have health insurance or limited prescription benefits through another insurance.

PACE or PACENET , Which Program is Right for You?

PACE:

If you are single and your total **previous calendar year's income** was less than **\$14,500**, or

If you are married and your combined total **previous calendar year's income** was less than **\$17,700** you may be eligible for **PACE**.

PACE has a **\$6** copayment for each covered generic prescription and a **\$9** copayment for each single-source brand name prescription that you have filled.

PACENET:

If you are single and your total **previous calendar year's income** was between **\$14,500** and **\$23,500**, or

If you are married and your combined total **previous calendar year's income** was between **\$17,700** and **\$31,500**, you may be eligible for **PACENET**.

PACENET has a monthly **\$40** cumulative deductible for each cardholder. Once that deductible has been met, **PACENET** has an **\$8** copayment for generic drugs and a **\$15** copayment for single-source brand name drugs. We track your out-of-pocket costs for you.

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 the fair market value of a prize, such as a car or a trip won in a lottery, contest or gambling
Unemployment	Note: Assets are not included as income.
Veterans' disability payments	
Cash public assistance	

What Documents should I send with my Application?

Proof of Age –

Birth date must be on document
(Send one of the following)

- Birth Certificate
- Baptismal Record
- Valid Driver's License
- Passport
- Military Discharge Papers
- Insurance Policy
- Photocopy of previous **PACE/PACENET** card

Proof of Residence –

Document must be 90 days old
(Send one of the following)

- Valid Driver's License or Owner's Card
- Utility Bill (phone, electric, etc.)
- Pre-printed Rent Receipts
- Social Security correspondence
- Income Tax Return with a pre-printed address label
- Nursing home patients: a letter on the facility's letterhead signed by the administrator that states the admission date

Proof of Income – Last Year's Income

- Income Tax Return and Schedules
- Social Security Document
- Benefit Letter for SSI Payments
- RRB-1099 and RRB-1099R Forms (Railroad)
- Pension/Annuities/IRS 1099 Forms
- W-2 Forms (Wages)
- Bank Statement (end-of-year statement)
- Court Order

How Can You Apply?

Fill out the form completely using black ink. If you are married, both you and your spouse can apply on the same form.

In Section D on the application form, fill in your total previous calendar year's income. If you are married, also include your spouse's income, even if only one of you is applying.

Attach a copy of your **age**, **residency** and **income** documents (Please do not send originals). Multiple documents may be copied on one page.

Include a signed Durable Power of Attorney or Guardianship document, if needed.

Complete the optional Health Survey form.

Send all required documents, health survey form and your signed, completed **PACE/PACENET** new enrollment application to:

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

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, report only your income.

If widowed, you should report only your previous year's income.

If you filed an income tax return last year, send a signed copy to verify your sources of income. **SSA 1099 form** must be used to verify Social Security income.

If you received both regular and Railroad Social Security, submit your SSA 1099 and RRB-1099 and RRB-1099R forms.

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/PACENET** Application.

- **If you are married and both of you are applying, you must check the box that you are filing for "Yourself and Your Spouse."**
 - **Individual applicants check the box that states "Yourself Only."**
- A. Applicant:** Complete all information in this section. Check the box if you have other health coverage and include copies of all health cards.
- B. Spouse:** If married, complete all information in this section. Check the box if your spouse has other health coverage and include copies of all health cards.
- C. Ethnic Origin:** Circle appropriate number. (Optional)
Residence: Circle appropriate number. (Required)
Marital Status: Circle the number that best describes your status. Include year separated or divorced. (Required)
- D.** List all previous year's income. Include **8 ½" x 11"** photocopies only.
- E.** Sign and date the application. Read the "**Certification and Authorization**" statements on the back of the application.
- F.** Power of Attorney or Guardian can sign for applicant(s). Include POA documents.
- G.** Witness/Preparer Signature is required if the applicant marks "**x**" in Signature.

Where to Send Your Completed **PACE/PACENET** Application.

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



1-800-225-7223
Within Pennsylvania

717-651-3600
Outside Pennsylvania

TDD
1-800-222-9004
(Telecommunication Device for the Deaf)

Application Fax Number

717-651-3608

E-mail Address

PACECares@fhsc.com

Nora Dowd Eisenhower
Secretary of Aging

Edward G. Rendell
Governor





PACE NEW ENROLLMENT APPLICATION

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

A	Your Last Name	First	Initial	Gender (Circle) M or F	Your Social Security #	Do you have health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Home Address				Apt. #	Birth Date (Mo) (Day) (Year) / /
City			State	Zip	Home Phone ()	

B	Spouse's Last Name	First	Initial	Gender (Circle) M or F	Spouse Social Security #	Do you have health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Spouse's Home Address				Apt. #	Birth Date (Mo) (Day) (Year) / /
City			State	Zip	Home Phone ()	

C	Ethnic Origin (Circle #) - Optional		Residence Type (Circle #) - Required		Marital Status (Circle #) - Required
	Applicant	Spouse	Applicant	Spouse	
1 White		1 White	1 Own	1 Own	1 Single/Widowed
2 African American		2 African American	2 Rent	2 Rent	2 Married
3 African Indian		3 American Indian	3 Nursing Home	3 Nursing Home	3 Divorced Since ____ (Year)
4 Hispanic		4 Hispanic	4 Personal Care Home	4 Personal Care Home	4 Married Living Separately Since ____ (Year)
5 Asian		5 Asian	5 Live with Relative	5 Live with Relative	
6 Other		6 Other	6 Other	6 Other	

D	LIST ALL INCOME FROM PREVIOUS YEAR (SINGLE APPLICANTS REPORT SINGLE INCOME. MARRIED COUPLES LIVING TOGETHER MUST REPORT COMBINED INCOME).			
If you did not receive regular Social Security last year, check here <input type="checkbox"/>		Applicant	Spouse	Total
If your spouse did not receive regular Social Security last year, check here <input type="checkbox"/>				
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 (Do not Subtract Losses)			5
6	Total Other Income: Wages, Salary, Bonuses, Commissions, Self-employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Compensation, Alimony, Support, Gifts and Inheritance totaling more than \$300, and Death Benefits Exceeding \$			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 income information listed is true, correct and complete.

E	Applicant Signature	Spouse Signature (if applying)
	Date ____/____/____	Date ____/____/____
F	Power of Attorney Signature (proof required)	Power of Attorney Signature (proof required)
	Date ____/____/____	Date ____/____/____
<input type="checkbox"/> Check box to send All Correspondence to Applicant POA Name Address City State ZIP Phone #		<input type="checkbox"/> Check box to send All Correspondence to Spouse POA Name Address City State ZIP Phone #
G	Witness/Preparer's Signature & Phone #	Witness/Preparer's Signature & Phone #
	Phone () Date ____/____/____	Phone () Date ____/____/____

CERTIFICATION AND AUTHORIZATION STATEMENTS

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, 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, Pennsylvania Department of Revenue, US Railroad Retirement Board, Social Security Administration or any other income provider to release a copy of my income tax return or other sources of income to the program to verify my eligibility.**

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.

**For questions or help in completing this application, please call our
Cardholder Services Department:**



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

Your Survey on Health and Well-Being

Social Security Number

Gender: Male Female

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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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| c. Had a family member or friend who helped pay for your medicine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| d. Gotten samples of a prescription for free from a doctor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| e. Gotten prescriptions for free from a clinic or hospital? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 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. In the past year, have you lost employer sponsored health insurance coverage? 1. Yes 2. No
12. Do you have access to the Internet? 1. Yes 2. No 3. Not Sure
13. Are you LIMITED in any way in any activities because of any impairment or health problem?
 1. Yes 2. No. **If No, Go to Question 18.**
14. What is the **MAJOR** impairment or health problem that limits your activities?

15. For HOW LONG have your activities been limited because of your major impairment or health problem? Please give the length of time. _____
16. 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
17. 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
18. What is your approximate height and weight? Height: ___ ft ___ in Weight: _____ pounds
19. What is your educational level? Please give highest grade completed. _____
20. Do you currently drive a car or other motor vehicle? 1. Yes 2. No
 If yes, about how many miles a week do you drive? _____
21. During the past year, did you have any benefits or insurance that helped pay for prescriptions?
 1. Yes 2. No 3. Not Sure
 If yes, what kind of prescription benefit or insurance did you have? (Check all that apply.)
 1. PACE/PACENET 2. Employer sponsored (for example, a retirement benefit)
 3. Medical Assistance/ACCESS 4. Self-purchased supplemental insurance / Medigap policy
 5. Other (please describe) _____

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"/>
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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.

1. Would you say that in general your health is:

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

2. 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.)

3. 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.)

4. 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.)

5. 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.)

6. 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). _____

7. 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

8. 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

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- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| a. Skipped doses of a medicine to make the prescription last longer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| c. Had a family member or friend who helped pay for your medicine? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| d. Gotten samples of a prescription for free from a doctor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 1. Yes, often | 2. Yes, sometimes | 3. No, never |
| e. Gotten prescriptions for free from a clinic or hospital? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | 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. In the past year, have you lost employer sponsored health insurance coverage? 1. Yes 2. No
12. Do you have access to the Internet? 1. Yes 2. No 3. Not Sure
13. Are you LIMITED in any way in any activities because of any impairment or health problem?
 1. Yes 2. No. **If No, Go to Question 18.**
14. What is the **MAJOR** impairment or health problem that limits your activities?

15. For HOW LONG have your activities been limited because of your major impairment or health problem? Please give the length of time. _____
16. 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
17. 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
18. What is your approximate height and weight? Height: ___ ft ___ in Weight: _____ pounds
19. What is your educational level? Please give highest grade completed. _____
20. Do you currently drive a car or other motor vehicle? 1. Yes 2. No
 If yes, about how many miles a week do you drive? _____
21. During the past year, did you have any benefits or insurance that helped pay for prescriptions?
 1. Yes 2. No 3. Not Sure
 If yes, what kind of prescription benefit or insurance did you have? (Check all that apply.)
 1. PACE/PACENET 2. Employer sponsored (for example, a retirement benefit)
 3. Medical Assistance/ACCESS 4. Self-purchased supplemental insurance / Medigap policy
 5. Other (please describe) _____

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