

Applying for \Box Self or \Box Self and Spouse

Anniheant Leat Nen Eilitt		A. APPLICAN			
Applicant Last Name First Nar	ne M/I	Gender M or F	Applicant Social Sec	curity Number (require	d)
			Applicant Date of Bi	rth (required)	
Street Address		Apt #	Applicant Primary P	hone Number ()
City	State	ZIP	Secondar	y Phone Number ()
			Applicant PA Driver'	s License or Photo ID	Number
Mailing Address (if you use a PO Box))				
PO Box			Marital Status	Residence Type	Race and Ethnicity
City	State	ZIP	(circle one) (required)	(circle one) (required)	Are you of Hispanic, Latino, or Spanish origin?
			1. Single/Widowed	1. Own 2. Rent	1. No or 2. Yes
MEDICARE	HEALTH INSU	JRANCE	2. Married	3. Nursing Home	
	uirod)		3. Divorced	4. Personal Care	What is your race? (Circle one or more)
MEDICARE NUMBER (req			Year:	Home / Assisted Living	1. White 2. Black or
MEDICARE PART A DATE				5. Living with Relative	African American
MEDICARE PART B DATE			4. Married Living Separately	6. Other	 American Indian or Alaska Native
			Year:	0. Other	4. Asian
Have you ever served in the military	? (circle one) 1.	No or 2. Yes		Are you	 Native Hawaiian or Other Pacific Islander
Are you a member of a religious ord	er? (circle one) 1.	No or 2. Yes		homebound? 1. No or 2. Yes	
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Spouse Last Name First Name	SECTION	•	INFORMATI		
	SECTION	N B. SPOUSE	INFORMATI	ON rity Number (required)	
	SECTION	N B. SPOUSE	INFORMATI Spouse Social Secu Spouse Date of Birth Spouse Primary Pho	ON rity Number (required) n (required) one Number ()	
Spouse Last Name First Name	SECTION	N B. SPOUSE Gender M or F	Spouse Social Secu Spouse Date of Birth Spouse Primary Pho Secondary R	ON rity Number (required) n (required) one Number () Phone Number ()
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Spouse Last Name First Name Street Address City Mailing Address (if you use a PO Box) PO Box City MEDICARE MEDICARE MEDICARE NUMBER (requ	SECTION M/I State State HEALTH INSU	Apt # ZIP	Spouse Social Secu Spouse Date of Birth Spouse Date of Birth Secondary F Spouse PA Driver's D Marital Status (circle one) (required) 1. Single/Widowed 2. Married 3. Divorced	ON rity Number (required) in (required) in (required) in e Number () Phone Number () Phone Number (License or Photo ID Nu Circle one) (required) 1. Own 2. Rent 3. Nursing Home 4. Personal Care Home / Assisted Living 5. Living with) Jumber Race and Ethnicity Are you of Hispanic, Latino, or Spanish origin? 1. No or 2. Yes What is your race? (Circle one or more) 1. White 2. Black or
Spouse Last Name First Name Street Address City Mailing Address (if you use a PO Box) PO Box City City MEDICARE MEDICARE NUMBER (requ MEDICARE PART A DATE	SECTION M/I State State HEALTH INSU	Apt # ZIP	NFORMATI Spouse Social Secu Spouse Date of Birth Spouse Primary Pho Secondary F Spouse PA Driver's I Marital Status (circle one) (required) 1. Single/Widowed 2. Married 3. Divorced Year: 4. Married Living	ON rity Number (required) in (required) in (required) in e Number () Phone Number () Phone Number (License or Photo ID Nu Residence Type (circle one) (required) 1. Own 2. Rent 3. Nursing Home 4. Personal Care Home / Assisted Living 5. Living with Relative) Jumber Race and Ethnicity Are you of Hispanic, Latino, or Spanish origin? 1. No or 2. Yes What is your race? (Circle one or more) 1. White 2. Black or African American 3. American Indian or Alaska Native 4. Asian
Spouse Last Name First Name Street Address City Mailing Address (if you use a PO Box) PO Box City City MEDICARE MEDICARE NUMBER (requ MEDICARE PART A DATE	SECTION M/I State State HEALTH INSU uired) 	Apt # ZIP ZIP	NFORMATI Spouse Social Secu Spouse Date of Birth Spouse Primary Pho Secondary F Spouse PA Driver's D Marital Status (circle one) (required) 1. Single/Widowed 2. Married 3. Divorced Year: 4. Married Living Separately	ON rity Number (required) in (required) in (required) in e Number () Phone Number () Phone Number (License or Photo ID Nu Residence Type (circle one) (required) 1. Own 2. Rent 3. Nursing Home 4. Personal Care Home / Assisted Living 5. Living with Relative) Jumber Race and Ethnicity Are you of Hispanic, Latino, or Spanish origin? 1. No or 2. Yes What is your race? (Circle one or more) 1. White 2. Black or African American 3. American Indian or Alaska Native



SECTION C - INCOM	IE VERIFICATIO	N (Required)	
Enter the GROSS INCOME FROM <u>PREVIOUS YEAR</u> in th If you have no income from the previous year, provide a lett If widowed, do not include your deceased spouse's income	er stating how your need	ds were met.	
Please do not subtract losses from income	Applicant	Spouse	Total
1. Gross Social Security and Gross SSI			
2. Railroad Retirement (RRB1099 and RRB1099R)			
3a. Pennsylvania State Employees' Retirement System Pension (SERS)			
3b. Pennsylvania Public School Employees' Retirement System Pension (PSERS)			
 Other Gross Pensions and Taxable Amounts of Annuities, 401ks and IRAs not listed in 3a or 3b 			
5. Interest, Dividends, Capital Gains, Prizes			
 Wages, Salary, Bonuses, Commissions, Self- Employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony, Support, Gambling, Gifts and Inheritance (only if over \$300), Death Benefits (only if over \$10,000), Royalties 			

By signing, I acknowledge that I have read the certification and authorization statements on the back of the Health & Prescription form and agree to the terms as stated, and that I have lived in Pennsylvania for at least 90 days prior to the date on this application, and that the age and income information listed is true, correct and complete.

SECTION D – APPLICANT SIGNATURE

Applicant Signature or Power of Attorney (POA) Signature	Spouse Signature or Power of Attorney (POA) Signature		
Date	Date		
Emergency Contact Name:	Emergency Contact Name:		
Emergency Contact Phone #: ()	Emergency Contact Phone #: ()		

SECTION E - CONSENT

Check box if you would like all correspondence sent to the perso	on named in Section E.
Name:	Phone Number:()
Address:	City/State:
Zip Code:	
SECTION F	– WITNESS/PREPARER
Witness/Preparer's Name (If not the Applicant)	Witness/Preparer's Name (If not the Applicant)
Name:	Name:
Name:	Name:

Your Survey on Health and Well-Being

		Social Security Number
Gender:Male	Female	

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 this one, as some 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 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 you and other older Pennsylvanians.

- 1. Are the questions in this survey being answered by the person applying for PACE/PACENET, or is someone else answering for this person?
 - $\hfill\square$ 1. I am the applicant listed above, and I am answering these questions.
 - □ 2. I am someone who is helping the applicant, but they are participating in answering the questions.
 - \Box 3. I am answering these questions for the applicant, and they are not participating in answering.
- 2. If you are not the PACE/PACENET applicant, what is your relationship to the applicant?

□ a. Spouse	b. Son or	🗆 c. Another	□ d. Friend or	🗆 e. Care	□ f. Other
or Partner	Daughter	Relative	Neighbor	Provider	

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

□ 1. Excellent	2. Very Good	🗆 3. Good	🗆 4. Fair	🗆 5. Poor
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4. 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.)

5. 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.)

6. 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.)

7. Compared to other persons your age, how would you describe your physical health?

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

- 8. In general, how much has your health changed in the past year?
 - □ 1. Much □ 2. Somewhat □ 3. About □ 4. Somewhat □ 5. Much Better Better
- 9. What is your approximate height and weight? Height: _____ft _____ in Weight: ______ pounds
- 10. What is your educational level? Please give highest grade completed.
- 11. During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?

\Box a. None \Box b. 1 time \Box c. 2 times \Box d. 3-5 times \Box e. 6-9 times \Box f. 10 or more
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PLEASE TURN THE PAGE OVER AND CONTINUE

12.	During the	last 12	months,	have	you	done	any	of the	e following:
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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
e. Avoided seeing a doctor because of concerns about the cost of prescription drugs?	□ 1. Yes, often	□ 2. Yes, sometimes	□ 3. No, never
 Do you have any problems reading or ur receive from your physician or pharmacis 	•	ructions about your medi	cations that you
 1. No, I have no problems reading and 2. Yes, sometimes I do have problems 	·	nstructions about my me	dications.

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).
- \Box c. Problems because English is not my native language.
- □ d. Other problems (please describe briefly)
- 14. 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

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.)

15. Have you ever been enrolled in a Medicare prescription drug plan?	🗆 1. Yes	🗆 2. No
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16. If yes, are you still enrolled?	🗆 1. Yes	🗆 2. No	3. Not Sure	
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17. 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				
b. My annual deductible was reasonable				
c. My co-pays were affordable				
d. My total out-of-pocket costs were reasonable				
e. My plan covered all the medicines my doctor prescribed				
f. My plan was convenient to use				
g. I understand how my plan worked and how to use it				

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

		If			Surve Also A	v							0				
		11	Spou	15C 15	11150 1	zhhi	ly mg								ər		
	Gender:	Ma	ale _	Fe	male					_							
(Eve que any only	would app en if you ha stions hav way affect ofor resear o improve	ave com e change t your elie rch abou	pleted a ed.) How gibility fo t the nee	similar ever, yc or enrolli eds of po	survey in ou are un ment in F eople wh	the pa der no PACE/P o enrol	ast, it is obligat PACENI II in PA	importation to c ET. All i CE/PAC	ant to compl nform CENE	com ete th ation T. Yo	plete ne su i is c our ai	e this o urvey, onfide nswer	one, nor entia s are	as s will y I anc e imp	ome (our d will toortar	of th lecis be us it in	ie sion in sed
1.	Are the q else answ				eing ansv	wered	by the	person	apply	ing fo	or PA	ACE/P	ACE	NE1	r, or is	sor	meone
2.	□ 2. I ar □ 3. I ar If you are	n someo n answei not the F	ne who i ring thes PACE/PA	s helpir e quest \CENET	• •	plicant, he app nt, wha	, but the llicant, a at is you	ey are p and the ir relati	oartici y are onshi	patin not p	g in partic he a	cipatin pplica	g in nt?		wering	g.	
	□ a. Spo or Pa	use □ artner	l b. Son Dau	or ghter	□ c. And Rel	other lative		d. Frier Neig	id or Ihbor		□e	. Care Prov			□ f.	Oth	er
3.	Would you	u say tha Excellent	•	eral you 2. Very			3. Goo	d		4. Fa	air	[□ 5.	Pooi	r		
4.	Now thin during th	e past 30) days w	as your		health	not go	od?	al illn	ess a	ind ir	njury, 1	for h	ow r	many	day	S
5.	Now think emotions,	, for how	many da	ays duri		ast 30 c	days wa	as your	•			•			ו		
6.	During the from doing	g your us	sual activ	/ities, su		elf-care	, work,	or recr			ental	healt	h ke	ер у	ou		
7.	Compare	d to othe Excellent	•	•	age, how Good		you de 3. Goo			hysio 4. Fa				Pooi	r		
8.	In genera 1. Mucl Wors	h □		ewhat	🗆 3. Abo	0		st year 4. Some Bette	ewhat		□ 5.	. Mucł Bette					
9.	What is ye	our appro	oximate	height a	and weigh	nt? F	leight:	ft _	i	n	W	eight:			poun	ds	
10.	What is	your edu	cational	level?	Please g	give hig	ghest gi	ade co	mplet	ted							
11.	was too	expensiv	e?		nany time c. 2 time	-				·		ption mes				more	e times

PLEASE TURN THE PAGE OVER AND CONTINUE

12.	During the	last 12	months,	have	you d	lone	any	of the	following:
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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
e. Avoided seeing a doctor because of concerns about the cost of prescription drugs?	□ 1. Yes, often	□ 2. Yes, sometimes	□ 3. No, never
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If yes, what kind of problems do you have? Please check all that apply.

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15. Have you ever been enrolled in a Medicare prescription drug plan?	🗆 1. Yes	🗆 2. No
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16. If yes, are you still enrolled?	🗆 1. Yes	🗆 2. No	3. Not Sure	
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d. My total out-of-pocket costs were reasonable				
e. My plan covered all the medicines my doctor prescribed				
f. My plan was convenient to use				
g. I understand how my plan worked and how to use it				

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

PACE/PACENET HEALTH & PRESCRIPTION FORM

Please return this completed form with a photocopy of any Health Insurance or Drug Coverage cards, along with your PACE/PACENET application.

Applicant Name:			Spouse Name:		
Section A Applicant Other Dru Do you have any other Dr Is this Retiree/Employer/L	ug Coverage?		Section B Spouse Other Drug Do you have any other D Is this Retiree/Employer	Drug Coverage?	
Does your card say any or MedicareRX Discount Card PDP Effective Date:	□ Tricare □ Veterans □ Access Card		Does your card say any	☐ Tricare ☐ Veterans ☐ Access Carc	
Drug Coverage Info			Drug Coverage Info		
Name of Plan:			Name of Plan:		
ID#			ID#		
RXPCN#			RXPCN#		
RXBIN#					
RXGRP#			RXGRP#		
	or "O")		CMS# (begins with an "h	H" or "S")	
CMS# (begins with an "H"					
Applicant Other Do you have any other He			Spouse Other H Do you have any other H		
Is this Retiree/Employer/L			Is this Retiree/Employer/		
Does your card say any or Discount Card HMO PPO	f the following?	□ Veterans □ Tricare	Does your card say any o Discount Card HMO PPO	PFFS SNP	□ Veterans □ Tricare
Effective Date:			Effective Date:		
Health Coverage Inf	ormation		Health Coverage In	formation	
Name of Plan:			Name of Plan:		
ID#			ID#		
PCN#			PCN#		
BIN#			BIN#		
<u>GRP#</u>			<u>GRP#</u>		
CMS# (begins with an "H"	or "S")		CMS# (begins with an "H	l" or "S")	

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 understand that PACE may provide my general information including drug claims and utilization data to outside sources for research purposes, as deemed appropriate by the Department.
- C. 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.
- D. I hereby waive the confidentiality of any health care information found in any Medicare Advantage plan (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.
- E. I agree to forgo any payment from any insurance company for any amount which has been paid by PACE on my behalf.
- F. I authorize the Internal Revenue Service, the Social Security Administration, the U.S. Railroad Retirement Board, the PA Dept. of Revenue, the PA Dept. of Transportation, the Public School Employees' Retirement System, the State Employees' Retirement System, 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).
- G. 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, handling any and all aspects of Part D on my behalf consistent with federal law, 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.

Need help with completing this application?

Call PACE Cardholder Services: 1-800-225-7223

PACE/PACENET P.O. Box 8806 Harrisburg, PA 17105-8806 <u>Fax</u>: 1-888-656-0372 <u>Online</u>: https://pacecares.magellanhealth.com <u>Email</u>: papace@primetherapeutics.com