New Jersey Department of Human Services
Division of Aging Services
State Health Insurance Programs for the Aged and Disabled
P.O. Box 715
Trenton, NJ 08625-0715

www.nj.gov/humanservices

UNIVERSAL APPLICATION FOR PHARMACEUTICAL ASSISTANCE TO THE AGED AND DISABLED (PAAD), SENIOR GOLD PRESCRIPTION DISCOUNT PROGRAM (SENIOR GOLD), LIFELINE, MEDICARE SAVINGS PROGRAMS (MSP) AND OTHER SPECIAL BENEFITS PROGRAMS

By completing the attached application, you may be eligible for benefits provided by the Pharmaceutical Assistance to the Aged and Disabled (PAAD), the Senior Gold Prescription Discount program or the Medicare Savings programs.

PAAD and Senior Gold are state-funded prescription programs that help eligible New Jersey residents with the cost of prescribed medication. The Medicare Savings Programs known as Specified Low-Income Medicare Beneficiary (SLMB) or SLMB Qualified Individual are two programs that pay Medicare Part B premiums.

While you are applying for assistance with your prescription and Medicare costs by filling out this application, you may be eligible for several other valuable benefits. For example, *if eligible for PAAD*, you may be eligible for benefits through the Lifeline utility assistance, Tenant's Lifeline Assistance and Hearing Aid Assistance to the Aged and Disabled programs. In addition, once you are on the PAAD program, you may qualify for a property tax freeze, and reduced motor vehicle fees.

Further, by completing this application, you may be screened for benefits provided by the Universal Service Fund (USF) and the Low-Income Home Energy Assistance Program (LIHEAP) – two more programs that help pay for utility costs. In addition, you will be screened for “Extra Help with Medicare Prescription Drug Plan Costs” – a program that helps pay Medicare Part D costs; New Jersey Hearing Aid Project (NJHAP) – a program that provides free refurbished hearing aids for eligible low-income seniors; and the New Jersey Supplemental Nutrition Assistance Program (NJ SNAP) – also known as Food Stamps. This program provides supplemental nutrition assistance to help people who meet certain income criteria buy groceries.

REMINDERS:

1. You must complete all income sections of this application.

2. You must complete the asset and resource sections of this application if your resources fall within the "Extra Help" guidelines and/or if you are applying for the Medicare Savings Programs.

3. If you are applying for Medicare Savings Programs, you must provide current documentation for all income and resources.

4. You must complete pages 11 and 12 if you are applying for Lifeline utility assistance or the Tenants Lifeline Assistance Program and if you wish to be screened for the Universal Service Fund (USF) and the Low-Income Home Energy Assistance Program (LIHEAP).

a. If you are not applying or not eligible for the Lifeline assistance programs, your information for USF or LIHEAP will not be screened for eligibility.

b. Information will be sent to USF/LIHEAP only during the heating season which runs from October through April.

5. You must provide all information and documentation for ***all*** programs for which you are applying before your eligibility for ***any*** program can be processed. For example, if you are applying for PAAD and Lifeline utility assistance and do not supply your utility bills, your PAAD eligibility determination **will not be processed** until your utility bills are received.

For More Information,

Visit **www.njpaad.gov** or, **www.njsrgold.gov** and

www.state.nj.us/humanservices/doas/services/slmb/

Or, Call 1-800-792-9745

2017 COMPARISON OF PAAD AND SENIOR GOLD

1-800-792-9745

Pharmaceutical Assistance to the Aged and Disabled Program	Senior Gold Prescription Discount Program
PAAD beneficiaries must fill out all pages of this application.	Senior Gold beneficiaries do not qualify for the Lifeline Credit/Tenants Lifeline Assistance Program or the Hearing Aid Assistance to the Aged and Disabled Program and, therefore, do not need to answer questions 27, 28, 29 and 30 of this application.
To be eligible for PAAD, you must be: 1. A resident of the State of New Jersey 2. Age 65 or older OR between 18 and 64 AND receiving Social Security Disability benefits 3. Have income: less than $26,655 (single) or less than $32,680 (married)	To be eligible for Senior Gold, you must be: 1. A resident of the State of New Jersey 2. Age 65 or older OR between 18 and 64 AND receiving Social Security Disability benefits 3. Have income: between $26,655 and $36,655 (single) or between $32,680 and $42,680 (married)
ID Number starts with **6**.	ID Number starts with **7**.
PAAD co-pay is: • $5 per PAAD covered generic drug • $7 per PAAD covered brand name drug.	Senior Gold co-pay for Senior Gold covered drugs is $15 + 50% of the remaining cost of the prescription or actual drug cost, whichever is less. (Co-pay will change with change in drug price.)
Catastrophic cap does not apply.	Catastrophic cap: $2,000 (single) $3,000 (married) Once the beneficiary's annual out of pocket expenses reach the catastrophic cap, co-pay is $15 (or the reasonable cost of the drug, whichever is less) for the balance of that eligibility period.
If Medicare-eligible, must enroll in a Medicare Part D Prescription Drug Plan unless prohibited from doing so.	**If Medicare-eligible, must enroll in a Medicare Part D Prescription Drug Plan unless prohibited from doing so.**
If a Part D plan is the primary payer for a drug covered on its formulary, PAAD will provide coverage as secondary payer if needed for that drug, and the PAAD beneficiary will pay the regular PAAD copayment for PAAD covered drugs. However, if a Part D plan does not pay for a medication because the drug is not on its formulary, PAAD beneficiaries will have to switch to a drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to the Part D plan.	If a Part D plan is the primary payer for a drug covered on its formulary, Senior Gold will provide coverage as secondary payer if needed for that drug, and the Senior Gold beneficiary will pay the regular Senior Gold copayment for Senior Gold covered drugs. However, if a Part D plan does not pay for a medication because the drug is not on its formulary, Senior Gold beneficiaries will have to switch to a drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to the Part D plan.
Third-party insurance must be billed BEFORE PAAD.	Third-party insurance must be billed BEFORE Senior Gold.
PAAD DOES NOT pay for diabetic testing supplies (for example, test strips and lancets).	Senior Gold DOES NOT pay for diabetic testing supplies (for example, test strips and lancets).

You must submit proof with this form.
Processing will be delayed if all necessary documents are not sent with this form.

If you are applying for **PAAD or Senior Gold** supply the following documents:

- Proof of principal place of residence, dated within the last 6 months
- Copy of the front and back of each health and prescription insurance card(s).

PAAD, Lifeline, HAAAD and Senior Gold programs require individuals be aged 65 or older OR over age 18 and under age 65 and receiving Social Security Disability benefits.

If you are 65 years of age or older and **do not** receive Social Security benefits, you must supply proof of your age.

Submit a COPY of one of the following to document DATE OF BIRTH:

- Birth Certificate
- Railroad Retirement record that indicates your date of birth
- Baptismal Certificate

If you cannot supply the above document(s), copies of any TWO of the following that indicate DATE OF BIRTH will be acceptable.

- Driver's License
- Delayed Birth Certificate
- State or Federal Census record
- School Record
- Foreign Passport
- Voting record
- Marriage Record
- Insurance Policy

SEASONAL OR TEMPORARY RESIDENCE IN NJ OF WHATEVER DURATION, DOES NOT QUALIFY AS YOUR PRINCIPAL PLACE OF RESIDENCE FOR PAAD, LIFELINE, HAAAD, SENIOR GOLD OR SLMB.

Submit two (2) proofs of residence with this application. Proofs must be current and dated. The date must be clearly visible and within the last 6 months.

Examples of acceptable proofs of residence are:

- Public utility records and receipts (e.g. bill for heating source, electric bill, telephone bill, etc.)
- Bills of business or professional people (e.g. doctors, pharmacies, etc.)
- Post Office Records

If you are applying for **Lifeline Utility Credit/Tenants Lifeline Assistance Program,** supply the following documents:

- Copy of your current gas and electric bill(s) if you are a utility customer, or
- Copy of your current lease agreement, if your rent includes the cost of electric/gas, and
- List the monthly amount of rent that you pay on page 11 of the application.

If you are also applying for assistance from the **Universal Service Fund (USF)/Low-Income Home Energy Assistance Program (LIHEAP)**, supply the above documents plus the following:

- If your home's primary source of heat is not gas/electric, submit a copy of your last bill from your heating supplier (e.g. oil, propane or wood supplier).

Please Note: In certain cases, additional documentation may be required.

FOR MEDICARE SAVINGS PROGRAMS APPLICANTS ONLY

If you are applying for the Medicare Savings Programs (MSP) known as the Specified Low-income Medicare Beneficiary (SLMB) or the Specified Low-income Medicare Beneficiary Qualified Individual (SLMB QI1), you will need to provide documentation to substantiate your assets and income.

To be eligible for MSP, you must:

a) **Be a resident of New Jersey**
b) **Be enrolled or eligible to enroll in Medicare Part A (hospital) and/or Medicare Part B (medical).**
c) **Have income and assets within the guidelines below**

2017	Income:	Assets:
Single	$16,281	$7,390
Married	$21,924	$11,090

NOTE: For married couples where only one individual is entitled to Medicare, that person's income must meet the single income standard. Having met that requirement, then the couple's combined income must meet the married income standard.

Financial documentation for income and assets must be current and **dated for the month** you complete and mail this application.

- ☐ Pension benefit (public and private): current pension stub or letter from pension payer listing gross benefit
- ☐ Salary/ Wage earnings (gross): current paystub
- ☐ Unemployment Benefits (gross): current statements
- ☐ Interest/Dividend earnings: year to date statements of earnings
- ☐ Workers Compensation/2nd Injury Fund: current statements
- ☐ Rental Income/Self-employment/Business Income (NET): documentation of expenses and income
- ☐ Other income not listed above: official documentation to verify gross amounts

For SLMB/SLMBQI1 programs ONLY, the following deductions will be taken from your gross annual income:

- $240 per year of unearned income, such as Social Security or pension benefits; and
- The first $780 per year of gross salary plus half of the remaining salary.

Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD),
Lifeline and Special Benefits Programs
Senior Gold Prescription Discount Program (Senior Gold)
Specified Low-income Medicare Beneficiary Program (SLMB) and
Specified Low-income Medicare Beneficiary Qualified Individual 1 (SLMB QI1) Program

This form will be scanned for computerized data capture. Please follow these instructions to ensure that your application is processed quickly and accurately.

- **Use blue or black ink. Do not use red ink or pencil.**
- **Print clearly in uppercase block letters (see examples below).**
- **Print only one number or letter in each box.**
- **Stay inside boxes.**
- **Correct errors with white correction fluid.**

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	0			

If you have questions or need help filling out this form, call our toll free number at 1-800-792-9745.

This form must be completed and returned to:

PAAD/Senior Gold
PO Box 715
Trenton, NJ 08646-07157

DO NOT SEND ORIGINAL SUPPORTING DOCUMENTS. SEND COPIES. ORIGINALS WILL NOT BE RETURNED.

A P 2 H P 0 1 1 5 0

New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and Special Benefits Programs
Senior Gold Prescription Discount Program (Senior Gold)
Specified Low-income Medicare Beneficiary (SLMB) and
Specified Low-income Medicare Beneficiary Qualified Individual (SLMB QI1)
PO Box 715, Trenton, NJ 08625-0715 Toll Free Hotline 1-800-792-9745

I am applying for:

Prescription Assistance ☐ **Lifeline Utility Benefit** ☐ **Medicare Savings Programs (SLMB/QI)** ☐

PLEASE PRINT YOUR NAME ON THE TOP OF EACH PAGE.

1. Enter your name, date of birth and sex. List your Social Security number. Use CAPITAL LETTERS. Print only one letter or number in each box. List date of birth verified by Social Security.

Last Name | **Suffix (Jr., Sr., etc.)**

First Name | **Middle Initial** | **Sex Male/Female**

Social Security Number ___ - ___ - ____

Date of Birth Month / Day / Year

2. If your spouse is also applying, both of you must complete separate applications. Even if your spouse is not applying, we need all of the questions answered and signatures for both of you, if married and living together.

Spouse's Last Name | **Suffix (Jr., Sr., etc.)**

First Name | **Middle Initial** | **Sex Male/Female**

Spouse's Social Security Number ___ - ___ - ____

Date of Birth Month / Day / Year

3. Please identify your current marital status. Please X only one box.

Married ☐ Separated* ☐ Single ☐

Widowed ☐ Divorced ☐

3a. Has your marital status changed in the last year? **YES** ☐ **NO** ☐ List the date of change ___ / ___ / ____ Month / Day / Year

*If you are separated from your spouse, call the toll-free number above to request an 'Affidavit of Separation' form which MUST accompany this application.

3b. Are you or your spouse, if married, residing in a long-term care facility (nursing home)? If YES, submit a letter from the facility indicating the date admitted.

YOU **YES** ☐ **NO** ☐

SPOUSE **YES** ☐ **NO** ☐

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

A P 2 H P 0 2 1 5 0

Name: _____

4. List your New Jersey address (actual physical street address) below and submit proof. Is this your principal place of residence? **YES** ☐ **NO** ☐

Street Address

City State

Zip Code -

SEASONAL OR TEMPORARY RESIDENCE IN NJ OF WHATEVER DURATION, DOES NOT QUALIFY AS YOUR PRINCIPAL PLACE OF RESIDENCE FOR PAAD, LIFELINE, HAAAD AND SENIOR GOLD.

Submit two (2) proofs of residence with this application. Proofs must be current and dated. The date must be clearly visible and within the last 6 months.

If you use a post office box or if you have a mailing address also complete question 5 below and submit proof of your actual street address. For those serving as Power of Attorney (POA) or in care of the applicant, please complete question 5 below and a copy of the POA/Guardianship, proof of the applicant's actual street address and the current POA/Guardian address.

Examples of acceptable proofs of residence are:

- ✓ Public utility records and receipts (e.g. bill for heating source, electric bill, telephone bill, etc.)
- ✓ Social Security records
- ✓ Bills of business or professional people (e.g. doctors, pharmacies, etc.)
- ✓ Post Office Records

5. Enter your Mailing Address (if different from home address).

Street Address

City State

Zip Code -

6. Did you and/or your spouse file a Federal or State income tax return last year? **YES** ☐ **NO** ☐

If YES, you must submit signed copies of each return, including all schedules, with this application.

A P 2 H P 0 3 1 5 0

Name: _____

Income

7. If you (or your spouse) receive income from any of the sources listed below, please enter the **total current YEARLY income**. **DO NOT LIST CENTS**. Check "NONE" if applicable. If applying for a Medicare Savings program, you must submit documentation to verify all income. Acceptable proofs are listed under each income source. **Only list Social Security income in Question 14**.

• Railroad Retirement *Current statement from RRB*	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Veterans *Current VA document. If "Aid and Attendance" is included in your benefit, submit a detailed breakdown*	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other Pensions *Pension stub or letter from pension payer listing gross benefit.*	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Annuities *Letter from annuity payer listing gross benefit.*	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other income not listed above, *including net rental income, workers compensation, alimony. (Specify below) Official documentation to verify amounts received.* Net Rental ☐ Alimony ☐ Worker's Comp ☐ Other ☐	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

8. Have any amounts included above decreased in the last two years? **YES** ☐ **NO** ☐

9. Have you (or your spouse) **worked** in the last 2 years?
YOU: **YES** ☐ **NO** ☐
SPOUSE (if living together): **YES** ☐ **NO** ☐

10. If you or your spouse answered **YES**, list **total current YEARLY** amounts below:

• Salary (gross, before payroll deductions) *Most recent paystub*	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Self-employed, what do you expect your net earnings or loss to be **THIS YEAR**?	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

• If you (or your spouse) expect a net loss, put an **X** here: **YOU:** ☐ **SPOUSE:** ☐

11. Have any amounts included above decreased in the last two years? **YES** ☐ **NO** ☐

Name: _____

12. If you (or your spouse) recently stopped working or plan to stop working, enter the month and year.

EXAMPLE:

For January–September, put a zero (0) in the first box.

May 2017 should read: 0 5 - 2 0 1 7

	Month	Year
YOU:		- 2 0
SPOUSE: (if living together):		- 2 0

- **If you are 65 or older, skip question 13.**
- **If you are married and living with your spouse and both you and your spouse are 65 or older, skip question 13.**

13. Do you (or your spouse, if married) have to pay for things that enable you to work? Extra Help with Medicare Part D will count only a part of your earnings toward the Extra Help income limit if you work and receive Social Security benefits based on a disability or blindness and you have work-related expenses for which you are not reimbursed. Examples of such expenses are: the cost of medical treatment and drugs for AIDS, cancer, depression, or epilepsy; a wheelchair; personal attendant services; vehicle modifications, driver assistance or other special work-related transportation needs; work-related assistive technology; guide dog expenses; sensory and visual aids; and Braille translations.

YOU:	**YES**	☐	**NO**	☐
SPOUSE (if living together):	**YES**	☐	**NO**	☐

14. If you (or your spouse) receive income from any of the sources listed below, enter the **total current YEARLY income**. If applying for a Medicare Savings Program, you must submit documentation to verify all income. Acceptable proofs are listed under each income source.

• Social Security Benefits (Net) *Proof of Social Security direct deposit*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐
• Medicare Part B Premium *if deducted from Social Security check*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐
• Medicare Part D Premium *if deducted from Social Security check*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐
• Interest (Including tax-exempt) *Year to date interest earning statements*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐
• Dividends *Year to date interest earning statements*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐
• IRA Distributions *letter from IRA payer listing gross distribution*	**YOU:**	**NONE** ☐	$ ☐☐ , ☐☐☐
	SPOUSE (if living together):	**NONE** ☐	$ ☐☐ , ☐☐☐

A P 2 H P 0 5 1 5 0

Name: _____

Low Income Subsidy and SLMB ASSET

To receive Medicare Part D's Extra Help, your resources must be no more than $13,820 if single and no more than $27,600 if married.

To receive SLMB benefits, your assets must be no more than $7,390 if single and no more than $11,090 if married.

IMPORTANT NOTICE:

The asset information WILL NOT be used as a requirement by the State of New Jersey for the PAAD, Lifeline, HAAAD or Senior Gold Programs. The asset information is required to determine eligibility for extra help Medicare Part D benefits and SLMB and will only be used for that purpose.

15. Are your savings, investments and real estate (other than your home) worth more than $13,820 if single? If married, are they worth more than $27,600? Include things you own by yourself, with your spouse or with someone else. DO NOT include the value of your home, vehicles, burial plots or personal possessions in this amount for Medicare Part D's Extra Help. REMEMBER: SLMB has a lower asset limit and assets are counted differently

YES ☐ **NO/ NOT SURE** ☐

If you put an x in the **YES** box, you are not eligible for the extra help, skip questions 16 through 24 and continue at question 25.

16. Enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married) or both of you own in the boxes below. Include items that either of you own with another person. If you or your spouse (if married) do not own an item listed, either separately, jointly or with another person, place an X in the NONE box.

- Bank accounts (checking, savings, and certificates of deposit) **NONE** ☐ $ ☐☐,☐☐☐
- Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments **NONE** ☐ $ ☐☐,☐☐☐
- Any other cash at home or anywhere else **NONE** ☐ $ ☐☐,☐☐☐

17. Do you (or your spouse, if living together) own a vehicle? **YES** ☐ **NO** ☐

Is the vehicle used for work or for transportation to medical care? **YES** ☐ **NO** ☐

List all vehicles (if you need more space attach an additional sheet of paper)

Owner's Name	Year/Make	Amount Owed	Current Value
			$ ☐☐,☐☐☐
			$ ☐☐,☐☐☐

Name: _____

18. Do you expect to use money from any sources listed in question 16 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU: **YES** ☐ **NO** ☐

SPOUSE (if living together)**:** **YES** ☐ **NO** ☐

19. Other than your home and the property on which it is located, do you (or your spouse, if married and living together) own any real estate?

YES ☐ **NO** ☐

If yes, please list value and send current tax bill to verify. $ ☐☐☐ , ☐☐☐

20. Your living situation may affect the amount of help you can get for Medicare Part D. Therefore, we need to know how many relatives who live with you (and your spouse, if married and living together) depend on you or your spouse to provide at least one-half of their financial support. Relatives may include anyone related to you by blood, marriage or adoption.

How many relatives who live with you and your spouse depend on you or your spouse to provide at least one-half of their financial support? **Do not include yourself or your spouse in this number**.
(Place an **X** in only one box.)

NONE	1	2	3	4	5	6	7	8	9 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

21. Do you (or your spouse, if living together) own any valuable personal property such as jewelry, coin/stamp collections, furs, etc.? (Do NOT include wedding or engagement rings.)

YES ☐ **NO** ☐

If yes, please list the value of all valuable personal property: $ ☐☐☐ , ☐☐☐

Social Security's Privacy Act

Section 1860 D-14 of the *Social Security Act* authorized the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. You do not have to give us the information requested. However, if you do not provide the information, we will be unable to make an accurate and timely decision on your application. We may provide information collected on this form to another Federal, State, or local government agency to assist us in determining your eligibility for the extra help or if a Federal law requires the release of information.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Name: _____

22. Liquid assets are cash or any item which can be easily converted to cash. These can include, but are not limited to, checking accounts, savings accounts, certificates of deposit, stocks, bonds, mutual funds, money market funds, individual retirement accounts (IRA), annuities, trusts, savings bonds, treasury bills or treasury bonds.

You must submit bank statements and/or financial statements. Statements must include:
- Name of financial institution (bank name)
- Account owner's name(s)
- All pages of each statement
- The first day of the month
- All account activity and balances (do not cross out or black out entries)

Also, you must identify the source of all deposits/transfers into the account(s) and provide proof of your Social Security deposit(s). If you have your Social Security or other income deposited directly onto a pre-paid debit card, you must submit the debit card statement(s) showing all balances.

List the type of account, financial institution (bank name), account number and balance of each account. Enter the money amounts of bank accounts or investments that either you, your spouse (if married) or both of you own in the boxes below. Include items that either of you own with another person. If you need more space, attach a separate sheet of paper.

If you do not own any bank accounts, you must explain how you cash your Social Security check.

Account type	Financial institution	Account number	Account balance/market value
			$,
			$,
			$,
			$,

23. Do you (or your spouse, if married) own life insurance policies? **YES** ☐ **NO** ☐

If YES, enter the total face value and cash surrender value of your and your spouse's policies below.

- Face value is the amount the policy pays at time of death.
- Cash surrender value is how much money you would get if you turned in your policies for cash right now.

You will need to call your insurance companies to request documentation showing the type of policy, (e.g. Term, Whole Life) and for these current values. You must submit current official documentation for all life insurance policies.

DO NOT send your life insurance policy or the chart or table of values from your policy.

		TOTAL FACE VALUE	TOTAL CASH SURRENDER VALUE
YOU:	**YES** ☐ **NO** ☐	$,	$,
SPOUSE:	**YES** ☐ **NO** ☐	$,	$,

Name: _____

24. Do you (or your spouse) have funds set aside for burial? List the current value of arrangements below. If none, place an **X** in the **NONE** box. You must **SUBMIT OFFICIAL DOCUMENTATION** of pre-paid funeral or other money for burial account(s).

a. Irrevocable arrangements (Funeral is prepaid and cannot be cashed in) What is the value?	**YOU:**	NONE ☐	$ ☐☐ , ☐☐☐
	SPOUSE: (if married)	NONE ☐	$ ☐☐ , ☐☐☐
b. Other pre-paid arrangements (Revocable arrangements) What is the value?	**YOU:**	NONE ☐	$ ☐☐ , ☐☐☐
	SPOUSE: (if married)	NONE ☐	$ ☐☐ , ☐☐☐
c. Burial space items (Plots, caskets, headstones, vaults, opening/closing costs) What is the value?	**YOU:**	NONE ☐	$ ☐☐ , ☐☐☐
	SPOUSE: (if married)	NONE ☐	$ ☐☐ , ☐☐☐
d. Other money for burial What is the value?	**YOU:**	NONE ☐	$ ☐☐ , ☐☐☐
	SPOUSE: (if married)	NONE ☐	$ ☐☐ , ☐☐☐

FOR OFFICE USE ONLY

A P 2 H P 0 9 1 5 0

Name: _____

25. Medicare Information

List your (and your spouse's, if married) Medicare Claim Number(s) and suffix or Railroad Retirement Number(s) and prefix exactly as it is shown on your Medicare card(s), if applicable. Indicate your (and your spouse's, if married) Medicare coverage and effective date(s).

YOU:

If NO Medicare coverage put an X here ► ☐

Medicare Claim Number ☐☐☐ - ☐☐ - ☐☐☐☐ - SUFFIX ☐☐ OR PREFIX ☐☐☐☐☐☐☐☐☐☐☐☐ Railroad Retirement Medicare Claim Number

Medicare Coverage:					Month	Day	Year
Part A (Hospital):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐
Part B (Medical):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐
Part D (Prescription):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐

If you are enrolled in a Medicare Prescription Drug Plan, identify your Prescription Drug Plan (PDP).

PDP Name: _____

SPOUSE (if married):

If NO Medicare coverage put an X here ► ☐

Medicare Claim Number ☐☐☐ - ☐☐ - ☐☐☐☐ - SUFFIX ☐☐ OR PREFIX ☐☐☐☐☐☐☐☐☐☐☐☐ Railroad Retirement Medicare Claim Number

Medicare Coverage:					Month	Day	Year
Part A (Hospital):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐
Part B (Medical):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐
Part D (Prescription):	**YES** ☐	**NO** ☐	effective date		☐☐ /	☐☐ /	☐☐☐☐

If you are enrolled in a Medicare Prescription Drug Plan, identify your Prescription Drug Plan (PDP).

PDP Name: _____

IMPORTANT NOTE: To be eligible for PAAD or Senior Gold, you must be enrolled in Medicare D if you are eligible for Medicare A or enrolled in Medicare B. If you are prohibited from enrolling in Medicare D for specific reasons, you must indicate that on question 26.

A P 2 H P 1 0 1 5 0

Name: _____

26. Health Insurance

If you and/or your spouse currently have health insurance coverage (with or without prescription benefits) with ANY insurance company, complete this section. **A copy of the front and back of your health insurance card(s) must be attached to your application.** If you have more than one (1) health insurance company, provide information for all of them. Use a separate page if needed.

YOU:

Do you have any health insurance coverage in addition to Medicare?

If yes, list: **YES** ☐ **NO** ☐

Health Insurance Organization: _____

- Does this insurance cover prescription drugs? **YES** ☐ **NO** ☐
- If yes, what is the prescription co-pay? $ _____

Is this health insurance coverage through a retirement or employer group plan? **YES** ☐ **NO** ☐

If **YES**, identify the employer/union name, address and telephone number.

Employer/Union Name: _____ Telephone Number: **( )** _____

Address: _____

Has your retiree/union health care plan informed you that if you enroll in a Medicare Prescription Drug Plan it will affect your (or your dependents) health insurance coverage OR that your current health insurance coverage is considered 'creditable coverage'?

If YES, submit a copy of the Retiree/Union documentation with this application. **YES** ☐ **NO** ☐

SPOUSE:

Do you have any health insurance coverage in addition to Medicare?

If yes, list: **YES** ☐ **NO** ☐

Health Insurance Organization: _____

- Does this insurance cover prescription drugs? **YES** ☐ **NO** ☐
- If yes, what is the prescription co-pay? $ _____

Is this health insurance coverage through a retirement or employer group plan? **YES** ☐ **NO** ☐

If **YES**, identify the employer/union name, address and telephone number.

Employer/Union Name: _____ Telephone Number: **( )** _____

Address: _____

Has your retiree/union health care plan informed you that if you enroll in a Medicare Prescription Drug Plan it will affect your (or your dependents) health insurance coverage OR that your current health insurance coverage is considered 'creditable coverage'?

If YES, submit a copy of the Retiree/Union documentation with this application. **YES** ☐ **NO** ☐

Remember to include copies of the front AND back of your health insurance card(s) and any pharmacy card(s).

FOR OFFICE USE ONLY _____ _____ _____ _____

A P 2 H P 1 1 1 5 0

Name: _____

27. Lifeline Utility Credit/Tenants Lifeline Assistance Program

Are you applying for Lifeline utility or tenants benefits? **YES** ☐ **NO** ☐
If **YES**, complete ONLY Section **A** or **B**, not both.

Check **NO** if you are **NOT an Electric or Natural Gas customer** AND **your utilities are NOT included in your rent payment.** Supplemental Security Income (SSI) beneficiaries should not apply, the Lifeline utility benefit is already included in monthly SSI checks. Only one ANNUAL $225 Lifeline benefit will be issued per household. When two or more persons share a household, Lifeline will only accept one application from that household.

A. LIFELINE CREDIT PROGRAM:

Enter your utility account number(s) exactly as listed on the bill(s). Submit **a copy of your most recent bill/statement(s)**. Bill(s) must show your name, address and account number. List the name as shown on the bill and identify that person's relationship to the applicant.

Utility Codes

01 Public Service Electric & Gas
02 Elizabethtown Gas
03 NJ Natural Gas
04 South Jersey Gas
05 Atlantic City Electric
06 Jersey Central Power & Light
07 Orange/Rockland Electric
08 Sussex Rural Electric
09 Butler Electric
10 Lavalette Electric Dept
11 Madison Water and Light Dept
12 Milltown Electric Dept
13 Park Ridge Electric Dept
14 Pemberton Electric Dept
15 Seaside Heights Electric Dept
16 South River Bd of Public Works
17 Vineland Municipal Utilities

For Office Use Only:
No Change ____ Cat/C _____
S/C _____ C/C _____

Electric Company Utility Code ☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on Electric Bill
First ☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relation to Applicant
Self ☐ Spouse ☐ Family member ☐ Landlord ☐ Other ☐

Gas Company Utility Code ☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on Gas Bill
First ☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Relation to Applicant
Self ☐ Spouse ☐ Family member ☐ Landlord ☐ Other ☐

B. TENANTS LIFELINE ASSISTANCE PROGRAM:

To be eligible for Tenants Lifeline you must be a tenant and have the cost of your electric and gas included in your rent. Only list your landlord's name and address if your electric and gas are included in your rent.

List the monthly amount of rent that you pay: $ ☐ , ☐☐☐

Landlord's Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Landlord's Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City, State, Zip Code ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐☐☐☐☐☐

Put an **X** in the box that most accurately describes your principal place of residence. **Please complete this section.**

Own House ☐ Condominium ☐ Apartment ☐ Boarding Home ☐
Rent House ☐ Mobile Home Site ☐ Assisted Living Facility ☐ Nursing Home ☐
Other ☐ Explain: _____

A P 2 H P 1 2 1 5 0

Name: _____

28. Universal Service Fund (USF)/Low Income Home Energy Assistance (LIHEAP) Program Eligibility

By providing the following information, your household may be screened for USF/LIHEAP eligibility. USF is an energy assistance program for low-income electric and natural gas customers provided by the New Jersey Board of Public Utilities. LIHEAP helps low-income families and individuals meet home heating costs and is provided by the New Jersey Department of Community Affairs. You must provide the information in this section in order to be screened for USF/LIHEAP eligibility and it will only be used for that purpose.

Screen me for: LIHEAP Only ☐ USF Only ☐ BOTH LIHEAP and USF ☐ Not Applying ☐

A. Please indicate the total number of persons currently residing at your principal place of residence (household), including you and your spouse (if living together):

☐☐

B. Please list the total gross annual income for all household members over the age of 18:

$ ☐☐☐ , ☐☐☐

C. If you pay for your own heat, identify the primary source of heat in your principal place of residence. If you select OTHER, please identify type. If you do not pay directly for your heat, go to question C1:

ELECTRIC ☐ GAS ☐ OTHER ☐

FUEL OIL ☐ PROPANE ☐ KEROSENE ☐ WOOD ☐ COAL ☐

Heating Fuel Supplier Name: _____

C1. If you do not pay for your own heat check the alternative that best describes your heating arrangement

Heat provided by public housing/rent subsidy ☐	Heat included in non-subsidized rent ☐	Share cost of heat with others ☐
Pay a separate charge to Landlord for heat ☐	Heat paid for by others ☐	Pay for secondary source of heat (such as a wood or kerosene stove, electric heater, etc.) ☐

29. Hearing Aid Assistance to the Aged and Disabled

Are you applying for Hearing Aid Assistance to the Aged and Disabled (HAAAD)? **YES** ☐ **NO** ☐

PAAD eligibles that purchase a hearing aid may receive a $100 payment to offset the cost of purchase.
If you would like to apply for HAAAD, submit the following with this application:
1) a physician's prescription or letter attesting to the medical necessity for obtaining a hearing aid, AND
2) a receipt for the recent purchase of the hearing aid.

30. Supplemental Nutrition Assistance Program

Do you want PAAD to submit your information to the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, to be screened for benefits? **YES** ☐ **NO** ☐

Name: _____

31. Signatures

I understand that the Social Security Administration (SSA) will check my statements and compare its records with records from Federal, State and local government agencies, including the Internal Revenue Service (IRS) to make sure the determination is correct. By submitting this application I am authorizing the SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, benefits, and pensions. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge.

I certify that to the best of my knowledge I meet the Programs' eligibility requirements and will notify the Programs immediately if my income/assets rise above the legal limit, or if I move from New Jersey, or if I become Medicaid eligible. If I am determined eligible based on my disability, I will return my eligibility card if I stop receiving Social Security Disability Benefits. I authorize the release of information necessary to determine my eligibility from the records in possession of the SSA, IRS, New Jersey Division of Taxation, New Jersey Division of Medical Assistance and Health Services, employers, banks, utility companies and others as the need arises. I authorize my physician(s) to release information concerning prescriptions that have been paid on my behalf by the Program. I hereby assign the State of New Jersey as my authorized representative, any right to drug benefits to which I may be entitled under any other plan of assistance or insurance, from any other liable third party or drug benefits under any other plan of governmental assistance. I certify that I am the utility customer of record or tenant at the address indicated as my principal place of residence. I understand that the State of New Jersey is entitled to repayment of incorrectly provided payments. It is further understood that I may be held liable for repayment of any benefits or payments which are determined to have been incorrectly provided. I am authorizing PAAD to disclose to other state agencies the financial information listed above, utility information and other individually identifiable information from my file, such as my name, date of birth, and social security number to start the application process for USF/LIHEAP, Supplemental Nutrition Assistance Program (SNAP), and the New Jersey Hearing Aid Project (NJHAP).

Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.

SECTION A

Your Signature:	Phone Number: ( ) -
Your Spouse's Signature:	Date: / /

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

First Name:	Last Name:	Phone Number:
		( ) -

SECTION B

If you are assisting someone else in completing this application, place an X in the box that describes who you are and provide your daytime phone number and address.

Family Member		HMO		Other Advocate		Social Worker	
Friend		Agency		Other, Specify: _____			

First Name:		Last Name:	
Street Address:		Apt #	
City:	State:	Zip Code:	

Preparer Signature:	Phone Number: ( ) -

MEDICARE PART D PDP ENROLLMENT ASSISTANCE FORM

Applicant Name:	
Telephone Number:	Social Security Number:

Please choose one:

1) ☐ **If I am determined eligible for PAAD, please ENROLL me in a Medicare Part D plan for which PAAD will pay the premiums.** I have listed my medications below.

2) ☐ **If I am determined eligible for PAAD, please DO NOT switch my current Medicare Part D Plan.** I will be responsible for the premiums.

3) ☐ **I am enrolled in a Medicare Advantage plan with prescription coverage.**

4) ☐ **I have prescription coverage through a retiree or union health plan, which has notified me NOT to enroll in a Medicare prescription drug plan.** I am enclosing a copy of the notification.

☐ I CURRENTLY DO NOT TAKE ANY PRESCRIPTION DRUGS.

List the name of the pharmacy you use:

	Drug Name	Strength	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Reminder Checklist!

You must supply documentation and complete all sections of the application related to the program(s) for which you are applying:

ALL APPLICANTS:

- ☐ Proof of residence
- ☐ Tax return, if filed
- ☐ Proof of age (only required if you are not receiving Social Security benefits)
- ☐ If separated from your spouse, you must submit a completed Affidavit of Separation form
- ☐ Complete all income sections of the application
- ☐ Signatures (for both applicant and spouse, if married)

PAAD/SENIOR GOLD:

- ☐ Health insurance/Pharmacy cards (copies of the front and back of each card)
- ☐ Medicare Part D PDP enrollment assistance form

LIFELINE UTILITY BENEFITS:

- ☐ Current electric and natural gas bill(s): must clearly show account number, service address and customer name.

MEDICARE SAVINGS PROGRAM(S):

- ☐ Income documentation for ALL income
- ☐ Asset documentation for all: bank accounts, investments, Real estate, burial arrangements and life insurance policies.