AGE 65 AND OLDER?
NEED PRESCRIPTION HELP?
WITH OR WITHOUT MEDICARE PART D?

You can be enrolled in PACE/PACENET even if you have health insurance or another prescription plan.

Sign up today!

PACE AND PACENET
WORKS WITH:
• MEDICARE PART D PLANS
• RETIREE/UNION COVERAGE
• EMPLOYER PLANS
• VETERANS’ BENEFITS

WE OFFER LOW PRESCRIPTION COPAYS

PACENET:
• $14,501 to $33,500 for a single person
• $17,701 to $41,500 for a married couple

PACE:
• $14,500 or less for a single person
• $17,700 or less for a married couple

LOW PRESCRIPTION COPAYS
Based on 30-day supply
PACE: $6 Generic; $9 Brand
PACENET: $8 Generic; $15 Brand

HOW YOU CAN APPLY
• Applications can be taken over the phone. Call us at 1-800-225-7223
• Please have your income and insurance information available.

• FILL OUT THE ENCLOSED APPLICATION
• Online: https://pacecares.magellanhealth.com
• Mail: PACE/PACENET, PO BOX 8806 HARRISBURG PA 17105-8806
• Fax: 1-888-656-0372
• Email: papace@magellanhealth.com

APPLICATION CHECKLIST:
• Complete both sides of the application form
• Complete the section marked for spouse - even if your spouse is not applying
• Complete the Health Survey
• Make sure your application contains a signature in Section D

60x559]QUESTIONS?
CALL CARDHOLDER SERVICES
1-800-225-7223
—
Hearing Impaired Callers Using TTY/TDD should call: 1-800-222-9004
—
24 HOUR FAX NUMBER
1-888-656-0372
—
EMAIL ADDRESS
papace@magellanhealth.com

Tom Wolf
GOVERNOR
Robert Torres
SECRETARY OF AGING

60x559]PACENET ELIGIBILITY
• 65 years of age or older
• Pennsylvania resident for at least 90 consecutive days
• Income requirements based on previous year gross income:

PACE
• $14,500 or less for a single person
• $17,700 or less for a married couple

PACENET
• $14,501 to $33,500 for a single person
• $17,701 to $41,500 for a married couple

MEDICARE PART D AND OTHER COVERAGE
PACE/PACENET works with Part D plans and other prescription drug plans such as Retiree, Union, Employer, Medicare Advantage (HMO, PPO) and Veterans (VA).

PACE/PACENET may help pay your Part D premium, including the full Late Enrollment Penalty (LEP).

PAPACE@MAGELLANHEALTH.COM
AGE, INCOME AND RESIDENCY VERIFICATION & YOUR RESPONSIBILITY

• 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.

INCOME INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING

• Gross social security and SSI, excluding medicare premiums
• Railroad retirement - RRB1099 and RRB1099R
• Gross pensions
• Salaries/wages/commissions
• Self-employment or partnership income/business income
• Alimony and spousal support money
• Taxable amount of annuities and IRAs
• Unemployment
• Cash public assistance
• Interest/dividends/capital gains
• Net rental income
• Royalties
• Workers’ compensation
• Death benefit payments over $10,000
• Spouse’s income if married, living together
• Gift and inheritance of cash or property over $300
• Any amount of money or the fair market value of a prize, such as a car or trip won in a lottery, contest, or gambling winnings

INCOME EXCLUDES:

• Medicare Part B Premiums
• Property Tax/Rent Rebates
• VA Aid and Attendance
• Certain AmeriCorps Vista payments
• Other person’s income living with you other than your spouse
• Damages received in a civil suit/settlement agreement
• Benefits granted under 306c of Workers’ Compensation Act
• SNAP/Food Stamps
• LIHEAP payments
• Black or White Lung Benefits
• Housing allowance for members of religious orders
• First $10,000 of death benefit payment
• Federal stimulus payments
• VA dependency and indemnity compensation

ASSETS are not counted.

SALE OF HOME OR PROPERTY

• If you sold your home, all capital gains must be declared as income within two years of the sale date, even if you did not file a State or Federal tax return.

NURSING HOME OR PERSONAL CARE HOME COSTS

• Nursing home or personal care home required documents:
  • Home agreement
  • Last two invoices from the home
  • Last two cancelled checks used to pay the home invoices, and/or last two bank statements that show the payments to the home
# PACE

**PO Box 8806**

Harrisburg, PA 17105-8806

**Need Help? Call 1-800-225-7223**

## Applying for □ Self or □ Self and Spouse

### SECTION A. APPLICANT INFORMATION

<table>
<thead>
<tr>
<th>Applicant Last Name</th>
<th>First Name</th>
<th>M/I</th>
<th>Gender</th>
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<tr>
<td>2. Married</td>
</tr>
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### SECTION B. SPOUSE INFORMATION

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<tr>
<th>Spouse Last Name</th>
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**MUST COMPLETE OTHER SIDE.**
SECTION C – INCOME VERIFICATION (Required)

Enter the GROSS INCOME FROM PREVIOUS YEAR in the appropriate boxes.
If you have no income from the previous year, provide a letter stating how your needs were met.
If widowed, do not include your deceased spouse’s income.

Please do not subtract losses from income

<table>
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<th>Applicant</th>
<th>Spouse</th>
<th>Total</th>
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<tr>
<td>1. Gross Social Security and Gross SSI</td>
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<tr>
<td>2. Railroad Retirement (RRB1099 and RRB1099R)</td>
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<tr>
<td>3a. Pennsylvania State Employees’ Retirement System Pension (SERS)</td>
<td></td>
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<td></td>
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<tr>
<td>3b. Pennsylvania Public School Employees’ Retirement System Pension (PSERS)</td>
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<tr>
<td>4. Other Gross Pensions and Taxable Amounts of Annuities, 401ks and IRAs not listed in 3a or 3b</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Interest, Dividends, Capital Gains, Prizes</td>
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<tr>
<td>6. 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</td>
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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

________________________________________ Date __-__

Emergency Contact Name:

Emergency Contact Phone #: ( )

Spouse Signature or Power of Attorney (POA) Signature

________________________________________ Date __-__

Emergency Contact Name:

Emergency Contact Phone #: ( )

SECTION E – CONSENT

☐ Check box if you would like all correspondence sent to the person named in Section E.

Name: __________________________ Phone Number: ( )

Address: __________________________ City/State: __________________________

Zip Code: __________________________

SECTION F – WITNESS/PREPARER

Witness/Preparer’s Name (If not the Applicant)

Name: __________________________

Phone #: ( )

Witness/Preparer’s Name (If not the Applicant)

Name: __________________________

Phone #: ( )

12/2021
Your Survey on Health and Well-Being

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?
   □ 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.
   □ 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 Daughter    □ c. Another Relative    □ d. Friend or Neighbor    □ e. Care Partner    □ f. Other Provider

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

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?

8. In general, how much has your health changed in the past year?

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?
    □ 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
12. 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
   e. Avoided seeing a doctor because of concerns about the cost of prescription drugs? 1. Yes, often  2. Yes, sometimes  3. No, never

13. 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) ________________________________________________

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

16. If yes, are you still enrolled?  □ 1. Yes  □ 2. No  □ 3. Not Sure

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

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.

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______  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?

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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?


8. In general, how much has your health changed in the past year?


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?

☐ 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

12/2021
12. 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  

e. Avoided seeing a doctor because of concerns about the cost of prescription drugs?  
   1. Yes, often  2. Yes, sometimes  3. No, never  

13. 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.  
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   If yes, what kind of problems do you have? Please check all that apply.  
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<th>Somewhat Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>a. My monthly plan premium was affordable</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>b. My annual deductible was reasonable</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>c. My co-pays were affordable</td>
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<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>d. My total out-of-pocket costs were reasonable</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>e. My plan covered all the medicines my doctor prescribed</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>f. My plan was convenient to use</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>g. I understand how my plan worked and how to use it</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>
### Applicant Name:

### Section A
**Applicant Other Drug Coverage**
Do you have any other Drug Coverage? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ...... ☐ Yes ☐ No

Does your card say any of the following?
- ☐ MedicareRX
- ☐ Tricare
- ☐ Discount Card
- ☐ Veterans
- ☐ PDP
- ☐ Access Card

**Effective Date:**

### Drug Coverage Information
**Name of Plan:**
**ID#**
**RXPCN#**
**RXBIN#**
**RXGRP#**
**CMS# (begins with an “H” or “S”)**

### Applicant Other Health Insurance
Do you have any other Health Insurance? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ...... ☐ Yes ☐ No

Does your card say any of the following?
- ☐ Discount Card
- ☐ PFFS
- ☐ Veterans
- ☐ HMO
- ☐ SNP
- ☐ Tricare
- ☐ PPO
- ☐ Access Card

**Effective Date:**

### Health Coverage Information
**Name of Plan:**
**ID#**
**PCN#**
**BIN#**
**GRP#**
**CMS# (begins with an “H” or “S”)**

---

### Spouse Name:

### Section B
**Spouse Other Drug Coverage**
Do you have any other Drug Coverage? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ...... ☐ Yes ☐ No

Does your card say any of the following?
- ☐ MedicareRX
- ☐ Tricare
- ☐ Discount Card
- ☐ Veterans
- ☐ PDP
- ☐ Access Card

**Effective Date:**

### Drug Coverage Information
**Name of Plan:**
**ID#**
**RXPCN#**
**RXBIN#**
**RXGRP#**
**CMS# (begins with an “H” or “S”)**

### Spouse Other Health Insurance
Do you have any other Health Insurance? ☐ Yes ☐ No
Is this Retiree/Employer/Union Coverage? ...... ☐ Yes ☐ No

Does your card say any of the following?
- ☐ Discount Card
- ☐ PFFS
- ☐ Veterans
- ☐ HMO
- ☐ SNP
- ☐ Tricare
- ☐ PPO
- ☐ Access Card

**Effective Date:**

### Health Coverage Information
**Name of Plan:**
**ID#**
**PCN#**
**BIN#**
**GRP#**
**CMS# (begins with an “H” 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
Fax: 1-888-656-0372
Online: https://pacecares.magellanhealth.com
Email: papace@magellanhealth.com