**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**

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

The attached NJ Save application is a source of help offered by the State of New Jersey that can save you up to $5,000 per year in prescription, Medicare and other costs.

Please complete and return the application, along with all requested documents, in the self-addressed postage paid envelope provided. This one application gives you access to numerous programs and other special benefits including the following:

- **Medicare Savings Programs (Specified Low-Income Medicare Beneficiary (SLMB) and SLMB Qualified Individual (SLMBQI-1) programs).** If eligible, these programs pay for your monthly Medicare Part B premium, which currently costs most people $144.60 per month; and
- **Pharmaceutical Assistance to the Aged and Disabled (PAAD) program or the Senior Gold Prescription Discount program.** The PAAD program helps with the cost of your prescribed medications, including the payment of certain Medicare Part D premiums and deductibles. Senior Gold is a prescription discount program for individuals not eligible for PAAD; and
- **Lifeline Utility Credit/Tenants Lifeline Assistance program.** This program offers an annual $225 utility benefit on electric and gas utility bills provided you meet the PAAD eligibility requirements; and
- **Hearing Aid Assistance to the Aged and Disabled (HAAAD) program.** This program provides a $100 reimbursement to help offset the purchase of a hearing aid if you meet the PAAD eligibility requirements; and
- **New Jersey Hearing Aid Project (NJ HAP).** This program can provide a free refurbished hearing aid if you are 65 years or older and meet PAAD income and residency guidelines; and
- **Screening for Extra Help with Medicare Part D.** This program covers Medicare Part D prescription drug plan costs, for those individuals eligible for PAAD; and
- **Screening for benefits provided by the Universal Service Fund (USF) and the Low-Income Home Energy Assistance Program (LIHEAP).** These are two more programs that help pay for utility costs, if eligible; and
- **Reduced motor vehicle fees.** This benefit is available through the Division of Motor Vehicles to those individuals eligible for PAAD and Lifeline; and
- **Property tax freeze.** This benefit is available through the Division of Taxation to all eligible individuals.

For more information,

visit **www.aging.nj.gov**

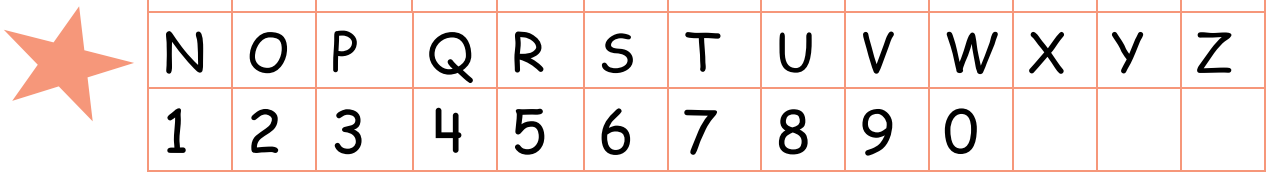
or call 1-800-792-9745

| Program | Eligibility Requirements | Benefits |
|---|---|---|
| **Medicare Savings Programs (MSP) (Specified Low-income Medicare Beneficiary (SLMB)/Specified Low-income Medicare Beneficiary/Qualified Individual 1 (SLMB/QI1)** | To be eligible for MSP, you must:<br>1. Be a resident of the State of New Jersey<br>2. Be eligible for or enrolled in Medicare Part A (Hospital) and Medicare Part B (Medical)<br>3. Have income at or below $17,232 (single) and $23,280 (married)<br>4. Have liquid resources of no more than $7,860 (single) or $11,800 (married) | Payment of Medicare Part B monthly premium and any late enrollment penalty for Medicare Part B. |
| **Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)** | To be eligible for PAAD, you must:<br>1. Be a resident of the State of New Jersey<br>2. Be age 65 or older OR between 18 and 64 AND receiving Social Security Disability benefits<br>3. Have income:<br>less than $28,399 (single)<br>or less than $34,817 (married) | PAAD co-pay is:<br>• $5 per PAAD covered generic drug.<br>• $7 per PAAD covered brand name drug.<br><br>Premium payment for certain Medicare Part D prescription drug plans. |
| **Lifeline Utility Credit Program and Tenants Lifeline Assistance Program** | **Same as PAAD** | Annual $225 benefit applied to utility bill, or for tenant's benefit, in the form of a check. |
| **Senior Gold Prescription Discount Program** | To be eligible for Senior Gold, you must:<br>1. Be a resident of the State of New Jersey<br>2. Be age 65 or older OR between 18 and 64 AND receiving Social Security Disability benefits<br>3. Have income:<br>between $28,399 and $38,399 (single)<br>or between $34,817 and $44,817 (married)<br><br>Senior Gold applicants do not qualify for the Lifeline Utility Credit/Tenants Lifeline Assistance Program or the Hearing Aid Assistance to the Aged and Disabled Program and, therefore, do not need to answer questions related to these programs. | 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.)<br><br>Catastrophic cap:<br>$2,000 (single)<br>$3,000 (married)<br>Once the beneficiary's annual out of pocket expenses reach the catastrophic cap, co-pay is $15 for the balance of that eligibility period. |

**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 | | | |

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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**
**Revenue Processing Center**
**PO Box 637**
**Trenton, NJ 08646-0637**

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

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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 ☐

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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, SENIOR GOLD AND 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.

If you use a post office box or 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 submit 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).

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.

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Name: _____

## Income

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

**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)<br>*Most recent paystub* | **YOU:**<br>**SPOUSE** (if living together)**:** | **NONE** ☐<br>**NONE** ☐ | $ ☐☐,☐☐☐<br>$ ☐☐,☐☐☐ |
| • Self-employment (net, after expenses)<br>*Proof of expenses and income* | **YOU:**<br>**SPOUSE** (if living together)**:** | **NONE** ☐<br>**NONE** ☐ | $ ☐☐,☐☐☐<br>$ ☐☐,☐☐☐ |

• If you (or your spouse) expect a net self-employment 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.

September 2020 should read: **0 9 - 2 0 2 0**

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

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Name: _____

## Low Income Subsidy and SLMB ASSET

**To receive Medicare Part D's Extra Help, your resources must be no more than $14,610 if single and no more than $29,160 if married.**

**To receive SLMB benefits, your assets must be no more than $7,860 if single and no more than $11,800 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 $14,610 if single? If married, are they worth more than $29,160? 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 or SLMB, 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 |
|---|---|---|---|
| | | | $ ☐☐,☐☐☐ |
| | | | $ ☐☐,☐☐☐ |

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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.)

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

**YES** ☐ **NO** ☐

$ ☐☐☐ , ☐☐☐

**Social Security's Privacy Act**

Section 1860 D-14 of the Social Security Act, as amended, authorizes the collection of information requested on this form. The information you provide will be used to enable the Social Security Administration (SSA) to determine if you are eligible for help paying your share of the cost of a Medicare Prescription Drug Plan. By submitting this application, you acknowledge and understand that the SSA will check your statements and compare its records with records from Federal, State and local government agencies, including Internal Revenue Service (IRS), to make sure the determination is correct. You do not have to give us the information requested. However, if you do not provide all or part of the information, we may not be able to make an accurate and timely decision on your application.

The SSA may disclose your information to another person or to another agency, in accordance with approved routine uses, which include but are not limited to determining your eligibility for certain government programs or to comply with Federal law.

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

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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:***

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 in 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** Lavallette 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 specify the type. If you do not pay directly for your heat, go to question C1.

ELECTRIC ☐ GAS ☐ OTHER ☐

FUEL OIL ☐ WOOD ☐
PROPANE ☐ COAL ☐
KEROSENE ☐

**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** ☐

A P 2 H P 1 3 1 5 0

Name: _____

**31.** 

## Signatures

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

By submitting this application, I authorize (1) the SSA to obtain and disclose information related to my income, resources and assets, foreign and domestic, consistent with applicable privacy laws and this information may include, but is not limited to, information about my wages, account balances, investments, benefits and pensions; (2) the release of information necessary to determine my eligibility or continued eligibility and verify my information from records in the possession of SSA, IRS, New Jersey Division of Taxation, New Jersey Division of Medical Assistance and Health Services, employers, financial institutions, utility companies and others; and (3) the disclosure of my information to other State agencies to start the application process for other benefits, which may include USF/LIHEAP, Supplemental Nutrition Assistance Program (SNAP) and New Jersey Hearing Aid Project (NJHAP).

I also authorize my physicians to release information about prescriptions that have been paid on my behalf by any Program. I hereby assign the State of New Jersey, as my authorized representative, any right to drug benefits to which I may be entitled from any other liable third party or under any other plan of assistance or insurance.

The social security number(s) provided (for the applicant, spouse, family members or dependents) will be used to match records by computer to determine eligibility or continued eligibility by verifying identity and financial information (including to check other financial records such as bank account information), to the extent it is useful in verifying eligibility, and to prevent duplicate participation and incorrectly paid benefits. Matching programs compare our records with those kept by other government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for benefit programs. Additional information on matching programs is available at any Social Security office.

I understand that I may be liable for repayment of incorrectly paid benefits. I understand that I am responsible to notify each Program immediately if my finances increase over the eligibility limit, or if I move from New Jersey, or if I become Medicaid eligible, or if my eligibility was based on my disability and I stop receiving Social Security Disability Benefits.

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.

### 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.** | | | |

New Jersey Department of Human Services
Division of Aging Services
PO Box 715
Trenton, NJ 08625-0715

# Demographic Information

1) Are you a Veteran? YES ☐ NO ☐

2) Citizenship/Immigration status: U.S. Citizen ☐ Legal Alien ☐ Asylee ☐ Refugee ☐

3) Please select your ethnicity:

- Not of Hispanic or Latino or Spanish origin ☐
- Mexican, Mexican American, Chicano ☐
- Puerto Rican ☐
- Cuban ☐
- Another Hispanic, Latino or Spanish origin ☐

4) Please identify your race:

- White ☐
- Black or African American ☐
- American Indian or Alaskan Native ☐
- Asian Indian ☐
- Chinese ☐
- Filipino ☐
- Japanese ☐
- Korean ☐
- Vietnamese ☐
- Other Asian ☐
- Native Hawaiian ☐
- Guamanian or Chamorro ☐
- Samoan ☐
- Other Pacific Islander ☐
- Unknown ☐

I certify that the information contained on this form is accurate to the best of my knowledge.

Applicant's Signature: Date: ☐☐-☐☐-☐☐☐☐

If you would like us to contact you through email in the future, please list your email address below:

_____

# 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. Bank statements must be current and dated for the month you complete this application

NJ Division of Aging Services

**STATE OF NEW JERSEY**
**Department of Human Services**

# Nondiscrimination Statement

## Discrimination is against the law.

The New Jersey Department of Human Services, Division of Aging Services (DoAS), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DoAS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In order for you to effectively communicate with DoAS, DoAS:

- Provides free aids and services to people with disabilities to communicate, such as:
  - ✓ Qualified sign language interpreter
  - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - ✓ Qualified interpreters
  - ✓ Information written in other languages

If you need these services to communicate with DoAS, please contact 1-844-577-7223.

If you believe that DoAS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, NJ Department of Human Services, Office of Legal and Regulatory Affairs, 222 South Warren Street, PO Box 700, Trenton, New Jersey 08625-0700, 1-888-347-5345 (telephone) or email: DHS-CO.OLRA@dhs.state.nj.us. You can file a grievance in person or by mail, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

**If you speak any other language, language assistance services are available at no cost to you. Call 1-844-577-7223.**

# Language Assistance Services Available

| | |
|---|---|
| ARABIC | ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-577-7223 |
| CHINESE | 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-577-7223 |
| FRENCH | ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-577-7223. |
| GUJARATI | સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-577-7223. |
| HAITIAN | ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-577-7223. |
| HINDI | ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-577-7223 पर कॉल करें। |
| ITALIAN | ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-577-7223. |
| KOREAN | 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-577-7223 번으로 전화해 주십시오. |
| POLISH | UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-577-7223. |
| PORTUGESE | ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-577-7223. |
| RUSSIAN | ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-577-7223. |
| SPANISH | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-577-7223. |
| TAGALOG | PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-577-7223. |
| URDU | خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844-577-7223. |
| VIETNAMESE | CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-577-7223 . |