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

PENNSYLVANIA LOTTERY

Brian M. Duke
SECRETARY OF AGING

Tom Corbett
GOVERNOR

AGE 65 AND OLDER?
NEED PRESCRIPTION HELP?
APPLY ANYTIME
* APPLICATION ENCLOSED *

PACE AND PACENET

WORKS WITH:
- MEDICARE PART D PLANS
- RETIREE/UNION COVERAGE
- EMPLOYER PLANS
- VETERANS' BENEFITS

WE OFFER LOW PRESCRIPTION COPAYS

PDA pennsylvania DEPARTMENT OF AGING

1-800-225-7223

PACE AND PACENET ELIGIBILITY

- 65 Years of age or older
- Pennsylvania resident for at least 90 consecutive days
- Must meet income requirements as listed below

IT'S EASY TO APPLY!

FOLLOW OUR HANDY CHECKLIST:

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

HOW YOU CAN APPLY

- CALL US AT 1-800-225-7223
  (Please have your income and insurance information available.)
- APPLY ONLINE AT:
  https://pacecares.magellanhealth.com/
- FILL OUT THE ENCLOSED APPLICATION
  - Mail to: PACE/PACENET, PO BOX 8806 HARRISBURG PA 17105-8806
  - Fax to: 1-888-656-0372
  - E-mail the application to: papace@magellanhealth.com

Important Information: You can be enrolled in PACE/PACENET even if you have health insurance or another prescription plan…Sign up today!

PACE FACTS

- A **single** person's total income from last year must be $14,500 or less.
- A **married** couple's total combined income from last year must be $17,700 or less.
- Covered drugs (based on 30-day supply):
  $6 Generic co-pay $9 Brand co-pay

PACENET FACTS

- A **single** person's total income from last year must be between $14,501 and $23,500.
- A **married** couple's total combined income from last year must be between $17,701 and $31,500.
- Covered drugs (based on 30-day supply):
  $8 Generic co-pay $15 Brand co-pay

(PACENET members may have a monthly premium to pay at the pharmacy.)

PACE/PACENET INCOME REQUIREMENTS —INCOME INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

- Gross Social Security & SSI (including Medicare Premiums)
- Railroad Retirement (RRB1099 & RRB1099R)
- Gross Pensions
- Salaries/Wages/Commissions
- Self-Employment or partnership income
- Alimony and Spousal Support Money
- Taxable Amount of Annuities and IRAs
- Unemployment
- Veterans' Disability Payments
- Cash Public Assistance
- Interest/Dividends/Capital Gains
- Net Rental Income
- Royalties
- Workers' Compensation
- Life Insurance Benefits (death benefits 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

IMPORTANT INFORMATION REGARDING THE SALE OF A HOME/PROPERTY

- If you sold your home, all capital gains must be declared as income within two (2) years of the sale date even if you did not file a State or Federal tax return. If you sold your home to pay for nursing home costs or used these proceeds to purchase another residence deeded in your name, it is not considered income.

PACE/PACENET EXCLUDABLE INCOME (DO NOT COUNT)

- Aid & Attendance payments from VA
- Certain AmeriCorps* Vista payments may be excluded
- Property Tax/Rent Rebates
- Other people'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
- Food Stamps
- LIHEAP payments
- Black or White Lung Benefits
- Assets

AGE, INCOME AND RESIDENCY VERIFICATION & YOUR RESPONSIBILITY

- It is important to carefully review the age, income & residency information that you report on your application. 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. The Program may request you to provide photocopies of your age, income, and residency documents to verify the information you reported on your application at any time.

- If it is determined that you incorrectly reported your age, income, or residency status, and that you are ineligible to receive these benefits, you may be required to repay the Program for any benefits it paid on your behalf.

INSTRUCTIONS FOR COMPLETING THE APPLICATION —NEED ASSISTANCE CALL 1-800-225-7223

SECTION A — APPLICANT INFORMATION
Please complete all fields in this section of the application.
Helpful Hints:
• Applicant Pennsylvania Address—The Pennsylvania address where you reside.
• Mailing Address—If your mail goes to a PO Box rather than your residential address, please fill this out. Otherwise, leave blank.

SECTION B — SPOUSE INFORMATION
If you are married, your spouse's information must be completed even if your spouse is not applying for coverage. Please complete all fields in this section of the application.

SECTION C — PREVIOUS YEAR INCOME
Include all income that you and your spouse (if married, living together) received during the previous year.

SECTION D — SPECIAL STATUS INDICATOR
Provide the requested information if you have been diagnosed with end-stage renal disease.

SECTION E — SIGNATURE
This Section is required. Please sign and date the application after you have read the "Certification and Authorization" statement included in the application booklet. If your POA signs for you, you must include a complete copy of the POA document.

SECTION F — POWER OF ATTORNEY (POA)
Complete this section if you have a Power of Attorney. If you want all correspondence sent to your Power of Attorney, be sure to check the box and include a complete copy of the POA document.

SECTION G — WITNESS/PREPARER
If someone else completed the application for you, please provide their name and telephone number.

MEDICARE PART D & OTHER PRESCRIPTION COVERAGE —
Complete the Health & Other Prescription Form
We work with all 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 premium directly to your Part D plan.
Contact us at 1-800-225-7223 for more details.

PACE

PO Box 8806
Harrisburg, PA 17105-8806

[redacted]

SECTION A. APPLICANT INFORMATION

Applying for ☐ **Self or** ☐ **Self and Spouse**

Applicant Last Name | First Name | M/I | **Gender M or F**

Applicant Social Security Number

Applicant Date of Birth

Street Address: | Apt #

Applicant Primary Phone Number ( )

Secondary Phone Number ( )

City | State | ZIP

Applicant PA Driver's License or Photo ID Number:

Mailing Address (if you use a PO Box)

PO Box:

City | State | ZIP

MEDICARE CLAIM NUMBER

_____

MEDICARE PART A DATE _____ - _____ - _____

MEDICARE PART B DATE _____ - _____ - _____

Marital Status (circle one)

1. Single/Widowed
2. Married
3. Divorced
   Year:
4. Married Living Separately
   Year:

Residence Type (circle one)

1. Own
2. Rent
3. Nursing Home
4. Personal Care Home
5. Living with Relative
6. Other

Race and Ethnicity (optional)

Are you of Hispanic, Latino, or Spanish origin?

1. No or 2. Yes

What is your race? (Select one or more)

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian or Other Pacific Islander

NOTE: IF YOU ARE MARRIED, YOU MUST FILL OUT SPOUSE INFORMATION

SECTION B. SPOUSE INFORMATION

Spouse Last Name | First Name | M/I | **Gender M or F**

Spouse Social Security Number

Spouse Date of Birth

Street Address: | Apt #

Spouse Primary Phone Number ( )

Secondary Phone Number ( )

City | State | ZIP

Spouse PA Driver's License or Photo ID Number:

Mailing Address (if you use a PO Box)

PO Box:

City | State | ZIP

MEDICARE CLAIM NUMBER

_____

MEDICARE PART A DATE _____ - _____ - _____

MEDICARE PART B DATE _____ - _____ - _____

Marital Status (circle one)

1. Single/Widowed
2. Married
3. Divorced
   Year:
4. Married Living Separately
   Year:

Residence Type (circle one)

1. Own
2. Rent
3. Nursing Home
4. Personal Care Home
5. Living with Relative
6. Other

Race and Ethnicity (optional)

Are you of Hispanic, Latino, or Spanish origin?

1. No or 2. Yes

What is your race? (Select one or more)

1. White
2. Black or African American
3. American Indian or Alaska Native
4. Asian
5. Native Hawaiian or Other Pacific Islander

MUST COMPLETE OTHER SIDE.

pennsylvania
DEPARTMENT OF AGING

SECTION C – INCOME VERIFICATION

If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **GROSS INCOME FROM PREVIOUS YEAR** in the appropriate boxes. If you (or your spouse) do not have income from the previous year, please provide a statement of validation of zero income. If widowed, include only your previous year's income (do not include your deceased spouse's income).

Please do not subtract losses from income	Applicant	Spouse	Total
1. Gross Social Security and Gross SSI			
2. Railroad Retirement (RRB1099 and RRB1099R)			
3a. Pennsylvania State Employees' Retirement System Pension (SERS)			
3b. Pennsylvania Public School Employees' Retirement System Pension (PSERS)			
4. Other Gross Pensions and Taxable Amounts of Annuities, 401ks and IRAs not listed in 3a or 3b			
5. Interest, Dividends, Capital Gains, Prizes			
6. Wages, Salary, Bonuses, Commissions, Self-Employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony, Support, Gambling, Gifts & Inheritance (only if over $300), Death Benefits (only if over $10,000)			

SECTION D – SPECIAL STATUS INDICATOR

Please check if you or your spouse have been diagnosed with End Stage Renal Disease: ☐ You ☐ Spouse

Applicant: Dialysis Start Date ____-____-____ Spouse: Dialysis Start Date ____-____-____

Transplant Date: ____-____-____ Transplant Date: ____-____-____

By signing, I acknowledge that I have read the certification and authorization 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 E – SIGNATURE

Applicant Signature or Power of Attorney (POA) Signature

_____ Date __ - __ - __

Spouse Signature or Power of Attorney (POA) Signature

_____ Date __ - __ - __

SECTION F – POWER OF ATTORNEY

☐ **Check box if you want all correspondence sent to your POA; complete POA documents are required if box is checked.**

Name

Address

City / State / ZIP

Phone #

☐ **Check box if you want all correspondence sent to your POA; complete POA documents are required if box is checked.**

Name

Address

City / State / ZIP

Phone #

SECTION G – WITNESS/PREPARER

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

Name

Phone #

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

Name

Phone #

Your Survey on Health and Well-Being

Social Security Number

Gender: ____Male ____Female

We would appreciate it if you would answer the following questions about your current health and well-being. (Even if you have completed a similar survey in the past, it is important to complete this one, as some of the questions have changed.) However, you are under no obligation to complete the survey, nor will your decision in any way affect your eligibility for enrollment in PACE/PACENET. All information is confidential and will be used only for research about the needs of people who enroll in PACE/PACENET. Your answers are important in helping us to improve upon the delivery of health services and benefits for you and other older Pennsylvanians.

1. Are the questions in this survey being answered by the person applying for PACE/PACENET, or is someone else answering for this person?
   - ☐ 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 or Partner ☐ b. Son or Daughter ☐ c. Another Relative ☐ d. Friend or Neighbor ☐ e. Care Provider ☐ f. Other

3. Would you say that in general your health is:
   ☐ 1. Excellent ☐ 2. Very good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

4. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
   _____ days (If none, enter zero on the line.)

5. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
   _____ days (If none, enter zero on the line.)

6. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
   _____ days (If none, enter zero on the line.)

7. Compared to other persons your age, how would you describe your physical health?
   ☐ 1. Excellent ☐ 2. Very good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

8. In general, how much has your health changed in the past year?
   ☐ 1. Much worse ☐ 2. Somewhat worse ☐ 3. About the same ☐ 4. Somewhat better ☐ 5. Much better

9. What is your approximate height and weight? Height: ___ ft ____ in Weight: _____ pounds

10. What is your educational level? Please give highest grade completed. _____

11. During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?
    ☐ 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:

	1. Yes, often	2. Yes, sometimes	3. No, never
a. Skipped doses of a medicine to make the prescription last longer?	☐	☐	☐
b. Spent less on food, heat, or other basic needs so that you would have enough money for your medicines?	☐	☐	☐
c. Had a family member or friend who helped pay for your medicine?	☐	☐	☐
d. Gotten samples of a prescription for free from a doctor?	☐	☐	☐
e. Avoided seeing a doctor because of concerns about the cost of prescription drugs?	☐	☐	☐

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 understood 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.

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 or Partner ☐ b. Son or Daughter ☐ c. Another Relative ☐ d. Friend or Neighbor ☐ e. Care Provider ☐ f. Other

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

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

4. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

   _____ days (If none, enter zero on the line.)

5. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

   _____ days (If none, enter zero on the line.)

6. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

   _____ days (If none, enter zero on the line.)

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

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

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

   ☐ 1. Much worse ☐ 2. Somewhat worse ☐ 3. About the same ☐ 4. Somewhat better ☐ 5. Much better

9. What is your approximate height and weight? Height: ___ ft ____ in Weight: _____ pounds

10. What is your educational level? Please give highest grade completed. _____

11. During the last 12 months, how many times did you decide not to fill a prescription because it was too expensive?

    ☐ 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:

	1. Yes, often	2. Yes, sometimes	3. No, never
a. Skipped doses of a medicine to make the prescription last longer?	☐	☐	☐
b. Spent less on food, heat, or other basic needs so that you would have enough money for your medicines?	☐	☐	☐
c. Had a family member or friend who helped pay for your medicine?	☐	☐	☐
d. Gotten samples of a prescription for free from a doctor?	☐	☐	☐
e. Avoided seeing a doctor because of concerns about the cost of prescription drugs?	☐	☐	☐

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 understood how my plan worked and how to use it	☐	☐	☐	☐

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

PACE/PACENET HEALTH & PRESCRIPTION FORM

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

Applicant Name:

Social Security Number:

Section A

Applicant Other Drug Coverage

Do you have any other Drug Coverage? ..... ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ..... ☐ Yes ☐ No

Is this Creditable Coverage? ..... ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ MedicareRX ☐ Tricare
☐ Discount Card ☐ Veterans'
☐ PDP ☐ Access Card

Drug Coverage Information

Name of Plan

ID#

RXPCN#

RXBIN#

RXGRP#

CMS#

Spouse Name:

Social Security Number:

Section B

Spouse Other Drug Coverage

Do you have any other Drug Coverage? ..... ☐ Yes ☐ No

Is this Retiree/Employer/Union Coverage? ..... ☐ Yes ☐ No

Is this Creditable Coverage? ..... ☐ Yes ☐ No

Does Your Card Say Any of the Following?

☐ MedicareRX ☐ Tricare
☐ Discount Card ☐ Veterans'
☐ PDP ☐ Access Card

Drug Coverage Information

Name of Plan

ID#

RXPCN#

RXBIN#

RXGRP#

CMS#

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

Health Coverage Information

Name of Plan

ID#

PCN#

BIN#

GRP#

CMS#

Eff Date

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

Health Coverage Information

Name of Plan

ID#

PCN#

BIN#

GRP#

CMS#

Eff Date

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. Power of Attorney or Guardianship documentation must be provided.

Need help in completing this application?
Call PACE Cardholder Services:

1-800-225-7223

MAIL
PACE/PACENET
P.O. Box 8806
Harrisburg, Pa 17105-8806

FAX

1-888-656-0372

APPLY ON LINE

https://pacecares.magellanhealth.com