ConnPACE Application

Please return to: ConnPACE, P.O. Box 5011, Hartford, CT 06102-5011

☐ ***Sí, me gustaría recibir la aplicación y notificaciónes del ConnPACE en Español solamente.***
(Yes, I would like to receive my ConnPACE application and notifications in Spanish only.)

If married, each spouse must complete a separate application and submit a separate $30 fee.

PLEASE COMPLETE ALL SECTIONS OF THE APPLICATION & SUBMIT PROPER DOCUMENTATION/PROOF.

1. IDENTIFICATION

____
Last Name First Name Middle Initial

____
Street Address Box or Apt #

______________________________ ***CT*** ______________
City State Zip Code

(_ _ _) _ _ _ - _ _ _ _
Telephone Number

_ _ _ - _ _ - _ _ _ _
*Your Social Security Number

****Your Social Security Number will serve as the basis for your ConnPACE client identification number, unless you specifically object.***

SEX: circle one Female Male

OFFICE USE

ID#____________________

AGE Y N

RES Y N

INC Y _____

DIS Y N S

AST Y _____

MCR______________

TOWN______________

CLERK #______________

2. MARITAL STATUS (check one)

☞ **Go to #3** ☞

- ☐ Single, Divorced, Widowed
- ☐ Married (Spouse's Social Security # _ _ _ - _ _ - _ _ _ _)
- ☐ Separated or spouse resides in a nursing home

3. DATE of BIRTH (proof required)

_____ / _____ / _____
Month Day Year

4. RACE *(optional)*

☐Caucasian ☐Native American ☐Black ☐Hispanic ☐Pacific Alaska Native ☐Asian

5. RESIDENCY proof required (drivers license, tax form, etc)

Have you been a Connecticut resident for the past 6 months? Circle **YES or NO**

6. DISABILITY proof required (Social Security Third Party Query Form)

Are you over the age of 18 and eligible for disability payments under the Social Security Disability (Title II) or the Supplemental Security Income (Title XVI) program? Circle **YES or NO**

7. INCOME INFORMATION proof of all income sources required

Office Use YR__________

Please use total income from the last calendar year, unless this year's income is lower. If you are married, you must fill in a social security amount for your spouse. If your spouse does not receive social security, enter zero.

List all of your income:
If joint information place amount in "Applicant" column

	Annual Amount Applicant	Annual Amount Spouse
➢ Adjusted Gross Income from the Federal Income Tax Return	$________	$________
➢ Social Security (minus Medicare Part B premiums), Supplemental Security Income, and Railroad Retirement Income	$________	$________
➢ Pensions, Retirement Income, Annuities, Veteran's Benefits	$________	$________
➢ Interest and Dividends	$________	$________
➢ Other income (Wages, Net Rental Income, Non-Taxable Income)	$________	$________

Continued on reverse side

8. INSURANCE **proof required, copy insurance card, front and back** **CIRCLE ONE**

a. Do you have State Medicaid (Title XIX) program coverage?.....**YES or NO**

b. Are you in spenddown for State Medicaid (Title XIX)?.....**YES or NO**

If YES, enclose a copy of your spenddown letter.

c. Other than Medicare Part D, do you have private insurance that pays for prescriptions?.....**YES or NO**

*If **YES**, please provide the information below:*

Name of Insurance Company________________________________ Policy Number________________________

Policy Start Date:________________________________Policy Stop Date:________________________________

d. Are you enrolled in: Medicare Part A?.....**YES or NO** Medicare Part B?.....**YES or NO**

e. What is your Medicare Number ID (HICN Number) found on your Red, White, & Blue Medicare Card? ________________

Please provide a copy of your Medicare Card, front and back.

f. Is the State paying your Medicare Part B premiums?.....**YES or NO**

g. Have you applied for Medicare's Prescription Drug Benefit (Part D)?..... **YES or NO**

h. Do you have a **Medicare Part D PRESCRIPTION DRUG PLAN (PDP)**?..... **YES or NO**

i. *If **YES**, please provide the information below:*

PDP Company Name:________________________________ PDP Policy Number:______________________

Policy Start Date:____/____/____ Policy Stop Date: ____/____/____ Monthly Premium: $___________*(If Applicable)*

Please provide a copy of your Medicare Part D Prescription Drug Plan Card, front and back.

ii. *If **NO**, would you like ConnPACE to select a Medicare Part D PDP for you?*..... **YES or NO**

******IF YOU HAVE MEDICARE PART A AND/OR B, YOU MUST BE ENROLLED IN A MEDICARE PART D PRESCRIPTION DRUG PLAN TO RECEIVE CONNPACE BENEFITS.******

9. ASSET INFORMATION FOR LOW INCOME SUBSIDY – EXTRA HELP: Completing this section will help determine if you qualify for Extra Help with Medicare Part D. Please answer the questions below.

a. Have you already applied for Extra Help? ☐ **YES** ***(go to question b)*** ☐ **NO** ***(go to question c)***

b. If you already applied for Extra Help, were you: ☐ **Approved** ☐ **Denied**

Please send a copy of the letter you received from Social Security on your request for extra help.

c. Will you apply for Extra Help? ☐ **YES** ☐ **NO**

If you HAVE NOT yet applied for Extra Help, you must answer the questions below. **Extra Help may still be available to you if you have dependent relatives who rely on you or your spouse to provide at least fifty-percent of their financial support.** To determine your assets, add your savings, investments, and real estate. Do not include your primary home, vehicles, burial plots, or personal possessions. **Please check ONLY one box**.

For Single, Widowed, Divorced or Separated Applicants:

My Assets exceed $11,710 ☐ **YES** ☐ **NO** ***(See Section 4 of Instructions)***

For Married Applicants:

My Assets exceed $23,410 ☐ **YES** ☐ **NO** ***(See Section 4 of Instructions)***

10. CERTIFICATION and AUTHORIZATION: I certify that the information on this form is true, accurate, and complete. I understand that if I provide false, fraudulent, or misleading information, I face fines and penalties under State law. I authorize the Social Security Administration, banking institutions, private insurance companies, and others to release information necessary to determine my ConnPACE eligibility. I authorize the ConnPACE program to release information about me, if applicable, as necessary for receipt of ConnPACE benefits and Medicare Prescription Drug Benefits and for the administration of the ConnPACE program, as permissible by federal or state law. I further authorize any health care provider to release all medical records pertaining to prescriptions covered by ConnPACE to assure that the services paid for by ConnPACE were appropriate. Social Security Number disclosure is required for the ConnPACE program under authority granted in 42 U.S.C. Section 405. Your Social Security Number will serve as the basis for your ConnPACE client identification number, unless you specifically object.

YOUR SIGNATURE OR MARK____**DATE**________________

Authorized Representative Signature____**DATE**________________

PLEASE COMPLETE ALL TEN SECTIONS, SIGN AND DATE THIS APPLICATION

ConnPACE Phone Numbers: Toll Free: 1-800-423-5026; Local/Out of State: 860-409-4555