New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD),
Lifeline and Special Benefit Programs
Senior Gold Prescription Discount Program (Senior Gold)
P.O. Box 715
Trenton, NJ 08625-0715

www.nj.gov/humanservices

UNIVERSAL APPLICATION FOR PAAD, SENIOR GOLD AND OTHER SPECIAL BENEFIT PROGRAMS

By filling out the attached application, you may be eligible for benefits provided by the Pharmaceutical Assistance to the Aged and Disabled (PAAD) or the Senior Gold Prescription Discount programs. **This application is ONLY for people who are applying for PAAD or Senior Gold benefits for the first time. If you are married, and you and your spouse wish to apply for benefits, each of you must complete a separate application.**

PAAD and Senior Gold are state-funded prescription programs that help eligible New Jersey residents with the cost of prescribed medication (including insulin, insulin needles, and needles for injectable medicines used for the treatment of multiple sclerosis).

While you are applying for assistance with your prescription costs by filling out this application, you may be eligible for several other valuable benefits *if you are eligible for PAAD*. For example, if eligible for PAAD, you may be eligible for benefits through the Lifeline utility assistance and Hearing Aid Assistance to the Aged and Disabled programs.

Once you are on the PAAD program, you may qualify for a property tax freeze, reduced motor vehicle fees, and Communications Lifeline.

Further, by filling out this application, you will be screened for benefits provided by the Universal Service Fund (USF) and the Low-Income Home Energy Assistance Program (LIHEAP) – two more programs that help pay for utility costs. In addition, you will be screened for "Extra Help with Medicare Prescription Drug Plan Costs" – a program that helps pay Medicare Part D costs; the Specified Low-Income Medicare Beneficiary (SLMB) or SLMB Qualified Individual programs – two programs that pay Medicare Part B premiums; and the New Jersey Supplemental Nutrition Assistance Program (NJ SNAP) – also known as Food Stamps, this program provides supplemental nutrition assistance to help people who meet certain income criteria buy groceries.

If it appears that you may be eligible for USF, LIHEAP, the "Extra Help," SLMB/SLMB QI-1, and/or NJ SNAP, PAAD will forward your information to these programs for eligibility consideration.

Turn this page over for a comparison of PAAD and Senior Gold.

For More Information,
Visit www.njpaad.gov or www.njsrgold.gov
Or, Call 1-800-792-9745

2016 COMPARISON OF PAAD AND SENIOR GOLD

1-800-792-9745

Pharmaceutical Assistance to the Aged and Disabled Program **www.njpaad.gov**	**Senior Gold Prescription Discount Program** **www.njsrgold.gov**
PAAD beneficiaries must fill out all pages of this application.	Senior Gold beneficiaries do not qualify for the Lifeline Credit/Tenants Lifeline Assistance Program or the Hearing Aid Assistance to the Aged and Disabled Program and, therefore, do not need to answer questions 24, 25, 26 and 27 of this application.
Income limit: less than $26,575 (single) less than $32,582 (married)	Income limit: between $26,575 and $36,575 (single) between $32,582 and $42,582 (married)
ID Number starts with **6**.	ID Number starts with **7**.
PAAD co-pay is: • $5 per PAAD covered generic drug • $7 per PAAD covered brand name drug.	Senior Gold co-pay for Senior Gold covered drugs is $15 + 50% of the remaining cost of the prescription or actual drug cost, whichever is less. (Co-pay will change with change in drug price.)
Catastrophic cap does not apply.	Catastrophic cap: $2,000 (single) $3,000 (married) Once the beneficiary's annual out of pocket expenses reach the catastrophic cap, co-pay is $15 (or the reasonable cost of the drug, whichever is less) for the balance of that eligibility period.
If Medicare-eligible, must enroll in a Medicare Part D Prescription Drug Plan unless prohibited from doing so.	**If Medicare-eligible, must enroll in a Medicare Part D Prescription Drug Plan unless prohibited from doing so.**
If a Part D plan is the primary payer for a drug covered on its formulary, PAAD will provide coverage as secondary payer if needed for that drug, and the PAAD beneficiary will pay the regular PAAD copayment for PAAD covered drugs. However, if a Part D plan does not pay for a medication because the drug is not on its formulary, PAAD beneficiaries will have to switch to a drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to the Part D plan.	If a Part D plan is the primary payer for a drug covered on its formulary, Senior Gold will provide coverage as secondary payer if needed for that drug, and the Senior Gold beneficiary will pay the regular Senior Gold copayment for Senior Gold covered drugs. However, if a Part D plan does not pay for a medication because the drug is not on its formulary, Senior Gold beneficiaries will have to switch to a drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to the Part D plan.
Third-party insurance must be billed BEFORE PAAD.	Third-party insurance must be billed BEFORE Senior Gold.
PAAD DOES NOT pay for diabetic testing supplies (for example, test strips and lancets).	Senior Gold DOES NOT pay for diabetic testing supplies (for example, test strips and lancets).

New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD),
Lifeline and Special Benefit Programs
Senior Gold Prescription Discount Program (Senior Gold)

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

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

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

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

This form must be completed and returned to:

PAAD/Senior Gold
Revenue Processing Center
PO Box 637
Trenton, NJ 08646-0637

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

Please see reverse for list of necessary documents.

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

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

- Proof of age (must show date of birth)
- Proof of current Social Security disability benefits if over age 18 and under age 65
- Proof of principal place of residence, dated within the last 6 months
- Copy of your Medicare Card
- Copy of the front and back of each health and prescription insurance card(s).

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

If you are 65 years of age or older…	*Send proof of date of birth.*
If you are over age 18 and under age 65 AND you receive Social Security Disability…	*Send proof of date of birth <u>AND</u> proof of current disability status.*

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

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

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

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

If you receive Social Security Disability, ALSO submit a COPY of one of the following to document disability status:

- Social Security Award Certification (SSA-L30) issued by the Social Security Administration within the last six months
- Verification through a benefit verification letter which indicates your current Social Security Disability status. You may obtain this letter by calling the Social Security Administration toll-free at 1-800-772-1213 (TTY 1-800-325-0778)

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

- Copy of your current gas and electric bill(s) if you are a utility customer, or
- Copy of your current lease agreement, if your rent includes the cost of electric/gas, and
- List the monthly amount of rent that you pay on Page 9 of the application.

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

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

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

New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and
Special Benefit Programs/Senior Gold Prescription Discount Program (Senior Gold)
PO Box 637, Trenton, NJ 08646-0637
Toll Free Hotline 1-800-792-9745

I am applying for: **Prescription Assistance** ☐ **Lifeline Utility Benefit** ☐

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 ☐

3b. 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 form 'Affidavit of Separation' which MUST accompany this application.

3c. 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** ☐

Name: _____

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

Street Address

City State

Zip Code -

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

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

If you use a post office box or if you have a mailing address also complete the address below and submit proof of your actual street address with this application. If using a Power of Attorney or a care of (c/o) address, complete mailing address below and submit proof of applicant's actual street address and Power of Attorney or Guardianship Papers.

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 (e.g. Third Party Query, Form SSA-2458, etc.)
- Bills of business or professional people (e.g. doctors, pharmacies, etc.)
- Post Office Records

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

Street Address

City State

Zip Code -

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

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

Name: _____

Income

7. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total current YEARLY income** in the appropriate boxes. **DO NOT LIST CENTS**. Do **not** list Social Security, wages and self-employment, public assistance, medical reimbursements or foster care payments here. If you (or your spouse) do not receive income from any of the sources listed below, place an **X** in the NONE box.

• Railroad Retirement	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Veterans	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other Pensions	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Annuities	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other income not listed above, including net rental income, workers compensation, alimony (Specify) Net Rental ☐ Alimony ☐ Worker's Comp ☐ Other ☐	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

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

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

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

• What do you expect to earn in wages before taxes **THIS YEAR**?	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• If self-employed, what do you expect your net earnings or loss to be **THIS YEAR**?	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

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

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

Name: _____

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

EXAMPLE:

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

May 2015 should read: 0 5 - 2 0 1 5

	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 and living together) have to pay for things that enable you to work? We will count only a part of your earnings toward the Medicare Part D 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.

**** Remember to send current proof of Social Security Disability with this application.****

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

14. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total current YEARLY income** in the appropriate boxes. **DO NOT LIST CENTS.** If you or your spouse do not receive income from any of the sources listed below, place an **X** in the **NONE** box.

• Social Security Benefits (Net)	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,
• Medicare Part B Premium (if deducted from Social Security check)	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,
• Medicare Part D Premium (if deducted from Social Security check)	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,
• Interest (Including tax-exempt)	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,
• Dividends	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,
• IRA Distributions	**YOU:**	**NONE**	$,
	SPOUSE (if living together):	**NONE**	$,

Name: _____

Low Income Subsidy and SLMB ASSET

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 Medicare benefits and will only be used for that purpose.

15. If you are single, a widow(er) or your spouse does not live with you, are your **savings**, **investments** and **real estate (other than your home)** worth more than $13,440? If you are married and living together, are they worth more than $26,860? Include the 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.**

YES ☐ **NO/ NOT SURE** ☐

If you put an x in the **YES** box, you are not eligible for the extra help, skip questions 16 through 21 and continue at question 22.

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

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

17.

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

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

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

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

Name: _____

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

YOU: **YES** ☐ **NO** ☐

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

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

YES ☐ **NO** ☐

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

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

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

21.

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

YES ☐ **NO** ☐

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

Social Security's Privacy Act

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

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

Name: _____

22. 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 must submit a copy of your (and your spouse's, if married) Medicare card(s).

YOU:

If NO Medicare coverage put an X here ► ☐

Medicare Claim Number ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐☐ SUFFIX

OR

PREFIX ☐☐☐☐☐☐☐☐☐☐☐☐ Railroad Retirement Medicare Claim Number

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

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

PDP Name: _____

SPOUSE (if married):

If NO Medicare coverage put an X here ► ☐

Medicare Claim Number ☐☐☐ - ☐☐ - ☐☐☐☐ - ☐☐ SUFFIX

OR

PREFIX ☐☐☐☐☐☐☐☐☐☐☐☐ Railroad Retirement Medicare Claim Number

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

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

PDP Name: _____

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

Remember to submit a copy of your Medicare card(s).

Name: _____

23. 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 _____ _____ _____ _____

Name: ______________________________

24. Lifeline Utility Credit/ Tenants Lifeline Assistance Program

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

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

A. LIFELINE CREDIT PROGRAM:

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

Utility Codes

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

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

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

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

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

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

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

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

B. TENANTS LIFELINE ASSISTANCE PROGRAM:

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

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

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

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

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

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

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

Name: _____

25. 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 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.

Are you applying for: LIHEAP Only ☐ USF Only ☐ BOTH LIHEAP and USF ☐ Not Applying ☐

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

2. Please list the total gross annual income for all household members over the age of 18: $ ☐☐☐ , ☐☐☐

3. What is your primary source of heat in your principal place of residence? If you select OTHER, please identify type:

ELECTRIC ☐ GAS ☐ OTHER ☐

FUEL OIL ☐ WOOD ☐
PROPANE ☐ COAL ☐
KEROSENE ☐

Heating Fuel Supplier Name: _____

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.) ☐

26. 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.

27. Supplemental Nutrition Assistance Program

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

Name: _____

28. Signatures

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

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

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

SECTION A

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

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

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

SECTION B

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

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

First Name: Last Name:

Street Address: Apt #

City: State: Zip Code:

Preparer Signature:	Phone Number: ( ) -