



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

PO BOX 637
TRENTON, NJ 08646-0637

JON S. CORZINE
Governor

www.nj.gov/health

HEATHER HOWARD
Commissioner

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.**

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).

If you are eligible for **PAAD** benefits, you also may be eligible for benefits through Lifeline, Universal Service Fund, and the Low-Income Home Energy Assistance Program – three programs that provide assistance with utility costs. Further, if eligible for **PAAD**, you may be eligible for Hearing Aid Assistance to the Aged and Disabled, reduced motor vehicle fees, and extra help to pay for the federal Medicare Part D prescription drug program.

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

2009 COMPARISON OF PAAD & SENIOR GOLD

TOLL FREE 1-800-792-9745

<i>Pharmaceutical Assistance to the Aged and Disabled program</i> www.NJPAAD.gov	<i>Senior Gold Prescription Discount program</i> www.NJSRGOLD.gov
2009 Income Limit: less than \$24,432 (single) less than \$29,956 (married)	2009 Income Limit: between \$24,432 and \$34,432 (single) between \$29,956 and \$39,956 (married)
ID Number starts with 6 .	ID Number starts with 7 .
PAAD co-pay is: <ul style="list-style-type: none"> • \$6 per covered generic drug • \$7 per covered brand name drug. 	Senior Gold co-pay 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.
<u>Example of co-pay with Medicare Part D:</u> Part D co-pay is \$25. A PAAD beneficiary's actual co-pay on that \$25 would be \$6 for generic drug or \$7 for brand name drug.	<u>Example of co-pay with Medicare Part D:</u> Part D co-pay is \$25. The actual co-pay on that \$25 for a Senior Gold beneficiary who hasn't yet reached the Senior Gold catastrophic cap would be \$20: \$15 Senior Gold co-pay (\$25 - \$15 = \$10) plus 50% of remaining cost of drug (50% of \$10 = \$5). Senior Gold beneficiary is paying \$15 + \$5 in this example for a total co-pay of \$20.
Requires Mandatory Generic Substitution for all brand versions of multi-source drugs unless the prescriber obtains prior authorization by providing medical justification for the brand version.	Requires Mandatory Generic Substitution for all brand versions of multi-source drugs unless the prescriber obtains prior authorization by providing medical justification for the brand version.
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 & lancets).	Senior Gold DOES NOT pay for diabetic testing supplies (for example, test strips & lancets).

Department of Health and Senior 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 and 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
- Social Security record that indicates your date of birth
- Baptismal Certificate
- 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
- Delayed Birth Certificate
- State or Federal Census record
- School Record
- Foreign Passport
- Voting record
- Marriage 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 by your local Social Security Office through the "Report of Confidential Social Security Beneficiary Information" (SSA-2458) or Third Party Query Form which indicates your current Social Security Disability status.

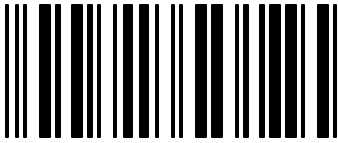
If you are applying for **Lifeline Utility Credit/Tenants Lifeline Assistance Program**, supply the following documents:

- Copy of your current gas and electric bill(s) if you are a utility customer or
- Copy of your current rent receipt and/or current lease agreement, if your rent includes the cost of electric/gas.

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 case, additional documentation may be required



**New Jersey Department of Health and Senior 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 Both

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	<input type="text"/>	Suffix (Jr., Sr., etc.)	<input type="text"/>
First Name	<input type="text"/>	Middle Initial	<input type="text"/>
Social Security Number	<input type="text"/>	Date of Birth	<input type="text"/>
		Month / Day / Year	

2. 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	<input type="text"/>	Suffix (Jr., Sr., etc.)	<input type="text"/>
First Name	<input type="text"/>	Middle Initial	<input type="text"/>
Spouse's Social Security Number	<input type="text"/>	Date of Birth	<input type="text"/>
		Month / Day / Year	

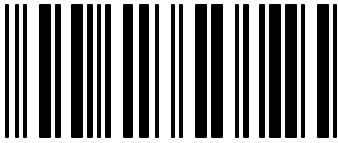
3. Please identify your current marital status. Please only one box.

Married	<input type="checkbox"/>	Separated*	<input type="checkbox"/>	Single	<input type="checkbox"/>
Widowed	<input type="checkbox"/>	Divorced	<input type="checkbox"/>		

3b. Has your marital status changed in the last year?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	List the date of change	<input type="text"/>
			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 <input type="checkbox"/>	NO <input type="checkbox"/>
	SPOUSE: YES <input type="checkbox"/>	NO <input type="checkbox"/>



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).

Address

City

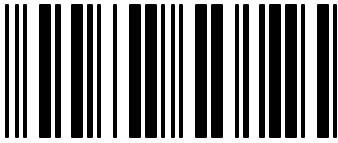
State

Zip Code

6. Did you and/or your spouse file a Federal, State or City 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 in the NONE box.

• Railroad Retirement	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Veterans	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Other pensions	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Annuities	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Other income not listed above, including net rental income, workers compensation, alimony (Specify) Net Rental <input type="checkbox"/> Alimony <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other <input type="checkbox"/>	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>

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:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• If self-employed, what do you expect your net earnings or loss to be THIS YEAR ?	YOU:	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
	SPOUSE (if living together):	NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>

• If you (or your spouse) expect a net loss, put an 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 2009 should read: **0 5 - 2 0 0 9**

YOU: Month Year

-

SPOUSE:
(if living together):

Month Year

-

- 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.

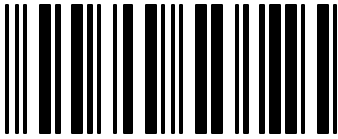
****Remember to send current proof of Social Security Disability with this application.****

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 in the **NONE** box.

• Social Security Benefits (Net)	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Medicare Part B Premium (if deducted from Social Security check)	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Medicare Part D Premium (if deducted from Social Security check)	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Interest (Including tax-exempt)	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• Dividends	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>
• IRA Distributions	YOU: SPOUSE (if living together):	NONE <input type="checkbox"/> NONE <input type="checkbox"/>	\$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> \$ <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/>



Name: _____

Low Income Subsidy ASSET

IMPORTANT NOTICE:

The asset information is required by the Social Security Administration so that it may determine if you are eligible for the extra help to use the Medicare Prescription Drug Coverage Plan. 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.

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 \$12,510? If you are married and living together, are they worth more than \$25,010? Include the things you own by yourself, with your spouse or with someone else. Do not include your home, vehicles, burial plots or personal possessions.

YES

NO/ NOT SURE

If you put an 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 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 \$,

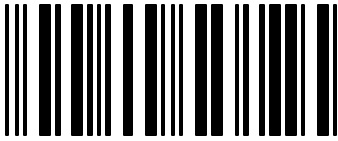
17. Do you own life insurance policies with a total face value of \$1,500 or more? Answer for you and for your spouse if your spouse lives with you.

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

If the answer for either you or your spouse is **YES**, enter the **CASH SURRENDER VALUE** below. This is how much money you would get if you turned in your insurance policies for cash right now. (You may need to call your insurance company to help answer this question.)

YOU: \$,

SPOUSE \$,
 (if living together):



Name: _____

18. Do you expect to use money from any sources listed in questions 16 or 17 to pay for funeral or burial expenses for yourself (or your spouse, if married and living together)?

YOU:	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
SPOUSE	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

(if living together):

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	<input type="checkbox"/>	NO	<input type="checkbox"/>
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Low income Subsidy Income

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 in only one box.)

NONE	1	2	3	4	5	6	7	8	9 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Does anyone provide or help you (or your spouse, if married and living together) pay for any of the following household expenses – food, mortgage, rent, heating fuel or gas, electricity, water and property taxes?

(Do not include food stamps, house repairs, help from a housing agency, an energy assistance program, Meals on Wheels or help with medical treatment and drugs.)

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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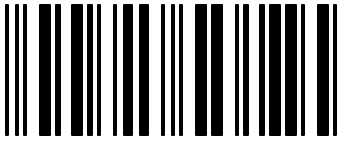
If you put an in the **YES** box, enter the **monthly** amount, or if the amount changes from month to month, enter the **average monthly** amount for the past year.

\$,

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: _____

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: (_____) _____

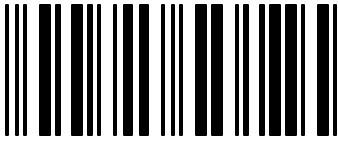
Address: _____

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 appropriate section below.

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

Electric Company	Utility Code	Account Number	
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name on Electric Bill			
First	<input type="text"/>	Last	<input type="text"/>
Relation to Applicant			
Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>
Family member	<input type="checkbox"/>	Landlord	<input type="checkbox"/>
Other	<input type="checkbox"/>		
Gas Company			
	Utility Code	Account Number	
	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name on Gas Bill			
First	<input type="text"/>	Last	<input type="text"/>
Relation to Applicant			
Self	<input type="checkbox"/>	Spouse	<input type="checkbox"/>
Family member	<input type="checkbox"/>	Landlord	<input type="checkbox"/>
Other	<input type="checkbox"/>		

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. To apply list the landlord's name and address.

Landlord's Name

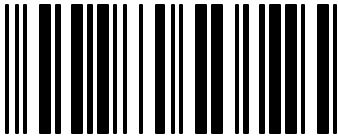
Landlord's Address

City, State, zip code

Put an in the box that most accurately describes your principal place of residence.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Own House | <input type="checkbox"/> Condominium | <input type="checkbox"/> Apartment | <input type="checkbox"/> Boarding Home |
| <input type="checkbox"/> Rent House | <input type="checkbox"/> Mobile Home Site | <input type="checkbox"/> Assisted Living Facility | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Other, Explain: _____ | | | |

For Office Use Only : N/C: _____ County Code: _____ S/C: _____ Category Code: _____



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 USF 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? (check one):

<input type="checkbox"/> ELECTRIC	<input type="checkbox"/> GAS	<input type="checkbox"/> OTHER	FUEL OIL <input type="checkbox"/>	WOOD <input type="checkbox"/>
			PROPANE <input type="checkbox"/>	COAL <input type="checkbox"/>
			KEROSENE <input type="checkbox"/>	

Heating Fuel Supplier Name: _____

If you do not pay for your own heat check the alternative that best describes your heating arrangement

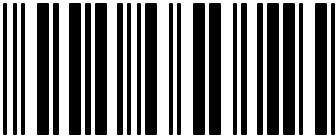
Heat provided by public housing/rent subsidy <input type="checkbox"/>	Heat included in non-subsidized rent <input type="checkbox"/>	Share cost of heat with others <input type="checkbox"/>
Pay a separate charge to Landlord for heat <input type="checkbox"/>	Heat paid for by others <input type="checkbox"/>	
Pay for secondary source of heat (such as a wood stove, a kerosene stove, electric heater, etc.)		<input type="checkbox"/>

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.



Name: _____

27.

Signatures

I/We understand that by submitting this application I am/we are declaring under the penalty of perjury that I/we have examined all the information on this form and it is true and correct to the best of my/our knowledge. I/We understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both. I/We understand that the Social Security Administration (SSA) will check my/our statements and compare its records with records from Federal, State and local government agencies, including the Internal Revenue Service to make sure the determination is correct. By submitting this application I am/we are authorizing 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/our wages, account balances, investments, insurance policies, benefits, and pensions.

I/We certify that to the best of my/our knowledge that I/we meet all Programs' eligibility requirements and will notify the program immediately if my/our income rises above the legal limit, or if I/we move from New Jersey, or if I/we become Medicaid eligible. If I/we are determined eligible based on my/our disability (ies), I/we will return my/ our eligibility card(s) if I/we stop receiving Social Security Disability Benefits. I/We authorize the release of information necessary to determine my/our eligibility from the records in possession of the Social Security Administration, Internal Revenue Service, New Jersey Division of Taxation, Division of Medical Assistance and Health Services, employers, banks, utility companies and others as the need arises. I/We authorize my/our physician(s) to release information concerning prescriptions that have been paid on my/our behalf by the Program. I/We understand that I/we may be visited by representatives of the Department of Health and Senior Services in order to verify my/our eligibility for benefits and determine availability of other prescription coverage and I/we authorize such visitations. I/We hereby assign the State of New Jersey as my/our authorized representative, any right to drug benefits to which I/we 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/We certify that I/we are the utility customer(s) of record or tenant(s) at the address indicated as my/our principal place of residence.

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 in the box that describes who you are and provide your daytime phone number and address.

Family Member <input type="checkbox"/>	Attorney <input type="checkbox"/>	Other Advocate <input type="checkbox"/>	Social Worker <input type="checkbox"/>
Friend <input type="checkbox"/>	Agency <input type="checkbox"/>	Other Specify: _____ <input type="checkbox"/>	
First Name:	Last Name:		
Street Address:	Apt #		
City:	State:	Zip Code:	
Preparer signature:	Phone Number: () - -		