ConnPACE

Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled

Program Information and Application

Annual Open Enrollment Period
November 15 to December 31

For Assistance, Please Call
1-800-423-5026
(Toll Free in Connecticut)

or

860-269-2029
(Farmington, Connecticut Area / Out-of-State)

Monday through Friday from 8:30 a.m. to 5:00 p.m.

www.ctdssmap.com

Connecticut Department of Social Services

~ Caring for Connecticut ~

December 2011

What is ConnPACE? Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled is a state funded program that helps elderly and disabled non-Medicare residents pay for certain prescription drugs, insulin, and insulin syringes. Participants pay a yearly **$45** enrollment fee and no more than a **$16.25** co-pay for each prescription covered by ConnPACE. **Applications are only accepted annually during the open enrollment period between November 15 and December 31, and must be received by December 31 for processing with an effective eligibility date of January 1.**

ConnPACE Benefits and Limitations – PLEASE KEEP THIS FOR REFERENCE

ConnPACE covers most prescription drugs, insulin, and insulin syringes and allows a 30-day supply or 120 units (tablets or capsules), whichever is greater, for each prescription.

For certain prescriptions, your physician or pharmacist is required to obtain **Prior Authorization (PA)** from ConnPACE before you can receive your prescription. This includes brand name drugs prescribed when a generic equivalent is available and **Early Refills (ER)** on prescriptions before **85%** has been used.

ConnPACE does not cover: antihistamines; contraceptives; cough preparations; anti-obesity drugs; experimental drugs; less than effective drugs, as designated by the FDA; multivitamin combinations; drugs prescribed for cosmetic purposes; smoking cessation gum; most over-the counter drugs; drugs for a lock-in enrollee not locked in to the billing pharmacy. In addition, ConnPACE will not pay for claims for services covered by other insurance.

ConnPACE does not cover drugs manufactured by pharmaceutical companies that do not participate in the ConnPACE Drug Rebate Program. The Department may make exceptions based on the medical needs of ConnPACE program participants**.**

If you have Medicare Part A, B or D, you are not eligible for ConnPACE. Please contact the Department of Social Services Adult Services Unit and apply for the Medicare Savings Program (MSP) at 1-877-485-6777 or at www.ct.gov/dss/MedicareSavingsPrograms.

The laws and regulations for the ConnPACE program are found at Connecticut General Statutes, Sections 17b-490 to 17b-498, inclusive and Regulations of Connecticut State Agencies, Sections 17b-262-684 to 17b-262-692, inclusive, and the Department's Uniform Policy Manual Chapter 8075.

You are eligible for ConnPACE if you meet all of the following requirements.

1. RESIDENCY: You must have lived in Connecticut for at least **6 months** immediately before applying for ConnPACE.

- **You must submit proof of residency** by providing a **copy** of one of the following:
  - ❑ Federal Income Tax Form 1040 *(complete & signed)*
  - ❑ Connecticut Driver's License
  - ❑ Social Security 1099 Form with Address
  - ❑ Bank Statement with address
  - ❑ Utility Bill with address: phone, light, or cable

The document you submit **must** prove that you lived in Connecticut at least six months before your application date.

2. AGE or DISABILITY: You must be at least **65 years old OR disabled and over 18 years old.** If disabled, you must be currently eligible to receive disability payment under the Social Security Disability Program or the Supplemental Security Income Program.

- **You must submit proof of age** by providing a **copy** of one of the following:
  - ❑ Your Birth Certificate
  - ❑ CT Driver's License or State ID Card
  - ❑ Social Security Documents with Date of Birth
  - ❑ Valid Passport / Naturalization Papers
- **You must submit proof of your disability by supplying a copy of the Social Security Administration Disability Award letter within 31 days of receipt. The Third Party Query Form (TPQY) will no longer be accepted for new applications.**

3. INCOME: Your adjusted gross income for the **current or previous calendar year** plus Social Security must be equal to or less than:

$26,000 if you are **SINGLE** or **$35,000** if you are **MARRIED**

If you are married but living apart, you are considered single, but any financial support received is counted as income. If you are married and living together, you must count both your income and the income of your spouse.

Please provide previous or current calendar year income. We will estimate a full year's income based on the documentation returned with your application.

The following sources are considered income:

- ❑ Pensions
- ❑ Annuities
- ❑ Wages
- ❑ Interest
- ❑ Veteran's Benefits
- ❑ Railroad Retirement
- ❑ Net Rental Income
- ❑ Social Security
- ❑ Supplemental Social Security
- ❑ All Non-taxable Income
- ❑ Disbursements from Trust Funds

You must provide copies of all sources of income. Submit a copy of your:

- ❑ Federal Income Tax Form 1040 (completed and signed) or proof of filed electronic return,
- ❑ Social Security Form 1099,
- ❑ Check or Bank statement showing direct deposit of Social Security, and/or
- ❑ Railroad Retirement / Pension(s)

If you do not file an income tax return, you must submit copies of all sources of income as listed above and documents to prove wages, net rental income, and bank statements showing annual interest earned.

4. INSURANCE and MEDICARE PRESCRIPTION DRUG COVERAGE (PART D):

You are eligible for ConnPACE during the open enrollment period if:

- **You are in Medicaid spend-down;**
- You have a private insurance plan with a maximum benefit, although you cannot use the ConnPACE card until after you have exhausted the maximum benefit through your private insurance plan. ConnPACE is the payer of last resort and will become effective only after your insurance benefits have been exhausted; or
- You have an Anthem Blue Cross & Blue Shield plan that pays for prescriptions after a hospital or outpatient stay. ConnPACE will pay before your hospitalization and after Anthem BC/BS no longer pays.

You are not eligible for ConnPACE if:

- You have a private insurance plan that pays for all or a portion of each prescription on a continuous basis or that is a deductible plan that includes prescriptions
- You have Medicare A, B, or D benefits
- You are currently covered by CT Medicaid (Title XIX) or Medicaid for Low Income Adults (MLIA).

When Applying to ConnPACE remember to:

- Complete **ALL information** in the enclosed application, front and back. **If you are applying as a married couple please be sure to complete all sections listed "Applicant" and "Spouse".**
- If this application is for both you and your spouse, **both of you must sign and date the application.**
- If this application is for a married couple, please send **only** one application and one set of documentation.
- If you are an individual applicant and married, please include documents for your spouse's income and assets.
- Enclose photocopies (8 ½" x 11" in size) of proof for **residency, income, age, disability (if applicable).**
- Enclose the Annual Registration fee of **$45** for an individual application, or **$90** for a married couple applying jointly, with a personal check or money order payable to: **ConnPACE.**
- Use paper clips and **please do not staple** any attachments to your application
- Mail your application, copied documents/proof, and annual registration fee in the envelope provided to:

ConnPACE P.O. Box 5011 Hartford, CT 06102

Some Frequently Asked Questions:

- **What are the qualifying events to the annual open enrollment period?** An individual can apply for ConnPACE outside of the Annual Open Enrollment period **only** within thirty-one (31) days of their **65th** birthday or becoming eligible for Social Security Disability Income or Supplemental Security Income.
- **When will I receive my ConnPACE card?** If your application is complete and you are eligible, you will receive a card in approximately 30 calendar days. The card is good for one year. Since we process the fee immediately, you may receive your cancelled check before hearing from us.
- **What if my application is not complete?** We will send you a letter requesting the missing information. ConnPACE cannot be approved until all missing information is submitted and approved.
- **What if I am found not eligible?** We will send you an explanation and refund your fee. You have a right to **file a written appeal** if you are denied eligibility.
- **Will I have to renew my eligibility? Yes. You must renew your ConnPACE eligibility annually.** We will send you a renewal form 75 days before your eligibility period expires. Call us if you do not receive it, or have lost it. **You must return the renewal form at least 45 days before your eligibility period expires or you must wait until the next annual open enrollment period.** Please notify ConnPACE within 10 days of any change in residential address, loss of your disability, or if you move out of state.

ConnPACE Application

Return to: ConnPACE, P.O. Box 5011, Hartford, CT 06102-5011
ConnPACE Phone Numbers: Toll Free 1-800-423-5026 or Local/Out of State 860-269-2029

This application is for: ☐ An Individual Applicant ($45 fee required) ☐ A Married Couple ($90 fee required)
Please complete all sections of the application and submit copies of documentation requested and the fee.

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

APPLICANT INFORMATION

If you and your spouse are applying together please complete the "SELF" and the "SPOUSE" columns.

PLEASE USE BLACK OR BLUE INK ONLY! PLEASE PRINT LEGIBLY!

	SELF	**SPOUSE** *(complete only if applying as a married couple)*
NAME And ADDRESS	________ ________ ____ (Last) (First) (MI) ________________ Apt #______ (Street Address) __________________CT_______ City ZIP Gender ☐ FEMALE ☐ MALE	________ ________ ____ (Last) (First) (MI) ________________ Apt #_______ (Street Address) __________________CT_______ City ZIP Gender ☐ FEMALE ☐ MALE
E-MAIL ADDRESS (if applicable)	______________________	______________________
TELEPHONE	(__________) ______________ - ______________________	
SOCIAL SECURITY #	________/_______/_________	_______/_______/________
DATE of BIRTH Proof of Age required	________/_______/_________ month / day / year	________/_______/________ month / day / year
RACE Optional-check one	☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Pacific Alaska Native ☐ Native American	☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Pacific Alaska Native ☐ Native American
MARITAL STATUS Required-check one	☐ Single, Divorced, Widowed ☐ Married ☐ Separated or spouse lives in nursing home	☐ Single, Divorced, Widowed ☐ Married ☐ Separated or spouse lives in nursing home
RESIDENCY Proof Required	I have been a Connecticut resident for the past 6 months ☐ YES ☐ NO	My spouse has been a Connecticut resident for the past 6 months ☐ YES ☐ NO
DISABILITY Proof Required	I am currently receiving disability benefits under SSDI (Title II) or the SSI (Title XVI) program? ☐ YES ☐ NO	My spouse is currently receiving disability benefits under SSDI (Title II) or SSI (Title XVI) program? ☐ YES ☐ NO

INSURANCE PRESCRIPTION DRUG COVERAGE INFORMATION

NOTE: If you are Medicare Eligible you NO longer qualify for ConnPACE benefits. Please contact the Department of Social Services Adult Services Unit to apply for the Medicare Savings Program at 1-(877)-485-6777.

Please answer all of the following questions:	**SELF**	**SPOUSE** *(if applicable)*
Are you or your spouse currently on STATE MEDICAID (Title 19)?	☐ YES ☐ NO	☐ YES ☐ NO
Are you or your spouse currently on SPEND DOWN?	☐ YES ☐ NO	☐ YES ☐ NO

Do you or your spouse have private insurance that pays for prescriptions? If YES, please provide information and send a copy of your insurance card(s)

SELF ☐ YES ☐ NO	**SPOUSE** *(if applicable)* ☐ YES ☐ NO
Company: ______________________	**Company:** ______________________
Policy #: ___________**Started:** ________**Ends:** _________	**Policy #:** ___________**Started:** _______**Ends:** _________

INCOME INFORMATION		
Please use total income from the last calendar year, unless this year's income is lower. Please list ALL of the annual income received for applicant and spouse (if applicable) and provide photocopies of all income sources. For married couples, please fill in a social security amount for yourself and spouse. If your spouse does not receive social security, enter zero.		
	SELF	**SPOUSE** *(if applicable)*
Adjusted Gross Income (Federal Tax Return)	$	$
Social Security Supplemental Security Income and/or Rail Road Retirement	$	$
Pensions, Retirement Income, Annuities, and/or Veteran's Benefits	$	$
Interest and/or Dividends	$	$
Other Income (Wages, Net Rental Income, Non-Taxable, etc.)	$	$
ANNUAL TOTAL	$	$

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 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.

APPLICANT SIGNATURE / MARK____**DATE**_________________________

SPOUSE SIGNATURE / MARK____**DATE**_________________________

****** After completing all sections please SIGN AND DATE THIS APPLICATION ******

AUTHORIZED REPRESENTATIVE / POWER OF ATTORNEY / CONSERVATOR CONTACT INFORMATION

If the applicant is unable to sign for themselves, please attach proof of relationship as the Authorized Representative, Power of Attorney, or Conservator

NAME:____**RELATIONSHIP:**_________________________

ADDRESS:_____________________________________**CITY / STATE / ZIP:**____

TELEPHONE: (________)_______-_______FAX: (________)_______-_______E-MAIL:___________________________________

FOR OFFICE USE ONLY	INCOME YEAR__________	CLERK # ____________	
SELF		SPOUSE (if applicable)	
SIGNATURE	TOWN CODE ________	SIGNATURE	TOWN CODE ________
AGE Y N		AGE Y N	
RES Y N	PDP	RES Y N	PDP
INC Y N	TPL	INC Y N	TPL
DIS Y N S		DIS Y N S	

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