

## **PLYMOUTH RETIREE ASSISTANCE FUND (PRAF) APPLICATION**

The Plymouth Retiree Assistance Fund (PRAF) was established to provide financial assistance to help reduce the cost of out-of-pocket medical expenses to eligible retirees of the Town of Plymouth and Plymouth Public Schools who are enrolled on a Town of Plymouth health insurance plan and are facing a financial hardship. The assistance provided by this fund will help cover costs for retiree's medical expenses to include co-pays, prescriptions, and other out-of-pocket expenses. This program is funded solely by voluntary employee and retiree donations.

This application must be filed with the PLYMOUTH RETIREE ASSISTANCE FUND COMMITTEE in the year for which you are requesting assistance.

ALL sections must be completed (use N/A if does not apply). Please print legibly and provide all requested supporting documentation as required.

### **1. APPLICANT INFORMATION:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

### **2. RETIREMENT STATUS:**

You are a retiree of:  Town of Plymouth  Plymouth Public Schools  MTRS

You are requesting reimbursement of medical expenses for:  Yourself  Spouse  Dependent

### **3. # IN HOUSEHOLD (anyone living with you):**

Adults (include self and spouse): \_\_\_\_\_ Age(s): \_\_\_\_\_ # of minors: \_\_\_\_\_ Age(s): \_\_\_\_\_

### **4. HEALTH INSURANCE:**

Are you enrolled on a Town of Plymouth Health Insurance Plan?  Yes  No

Which plan are you enrolled on:  Blue Choice  Blue Care Elect  Access Blue  Medex  Managed Blue

Do you cover dependents on your plan?  Yes  No

If yes, name of dependents covered under your plan:

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Do you have any other health insurance?  Yes  No

### **5. MARITAL STATUS: (please check all that apply to you)**

- Single
- Married
- Divorced
- Widowed

## 6. ADDITIONAL ASSISTANCE:

Please list any additional assistance you receive from the Town of Plymouth (i.e. Senior Tax Credit, Veteran's Assistance, Exemptions, Abatements)?

Have you received assistance from the Retiree Assistance Fund before?  Yes  No

If yes, when?

**7. REIMBURSEMENT REQUESTED** (copies of receipts must be provided):

DATE OF SERVICE:	PROVIDER:	TYPE OF EXPENSE:	TOTAL PAID:
_____	_____	_____	\$_____
_____	_____	_____	\$_____
_____	_____	_____	\$_____
_____	_____	_____	\$_____

You may add a separate page if needed.

**8. ADDITIONAL EXPLANATION:** Please use this space to provide information you would like the Committee to consider when reviewing your application. You may add a separate page if needed.

## 9. SIGNATURE.

By signing below, I certify that this application has been prepared or examined by me. Under the pains and penalties of perjury, I declare that, to the best of my knowledge and belief, this application and all attached documents and statements are true, correct, and complete, and I have not omitted any required information.

**DATE:** \_\_\_\_\_

**Applicant (PRINT NAME & SIGN)**

Did someone help you with this application? If so, please have them complete this section:

**DATE:** \_\_\_\_\_

**PRINT NAME & SIGN**

**Phone:**

**Email:**

**APPLICATIONS FOR REIMBURSEMENT OF MEDICAL EXPENSES MUST BE  
SUBMITTED IN THE YEAR THAT SERVICES WERE RECEIVED**

Applications are considered on a monthly basis.

## **CHECKLIST FOR SUBMISSION (SKIP AN ITEM IF IT DOES NOT APPLY TO YOU):**

- All sections of the application are complete and legible.
- The applicant has signed the application.
- Proof of ID (copy of current Driver's License, State ID, Passport, or Military ID)

Most recent copies of the following items are included, if relevant:

- Current tax returns**
- Proof of Town of Plymouth insurance**
- Medical receipts for requested reimbursement**

## **NOTICES**

**ASSISTANCE FUND:** You may be eligible to receive assistance in paying your medical expenses if you do not have the financial resources to pay them. Qualifications are established locally by the Plymouth Retiree Assistance Fund Committee.

**WHO MAY FILE AN APPLICATION:** You may submit an application if you are a retiree of the Town of Plymouth or Plymouth Public Schools, are enrolled on a Town of Plymouth health insurance plan, AND meet all qualifications set forth by the Committee.

**PAYMENT OF REIMBURSEMENT:** Filing an application does not guarantee approval of reimbursement. Applications are reviewed on a monthly basis. If approved, reimbursement will be made by check.

**ASSISTANCE FUND DISPOSITION:** After applying for Committee assistance, you may be required to provide the Committee with further information and supporting documentation to establish your eligibility. You will be notified in writing whether an award has been granted or denied.

### **COMMITTEE SIGNATURES:**

<b>Susan Page, Committee Member (PREA)</b>	<b>Approved</b> _____	<b>Denied</b> _____
<b>Tom Pinto, Committee Member (IAC)</b>	<b>Approved</b> _____	<b>Denied</b> _____
<b>Dale Webber, Committee Member (Retirement Board)</b>	<b>Approved</b> _____	<b>Denied</b> _____