

## INSTRUCTIONS FOR COMPLETING THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM APPLICATION

The Special Pharmaceutical Benefits Program (SPBP) is administered by the Pennsylvania Department of Public Welfare.

The SPBP provides payment for certain HIV/AIDS drug therapies for eligible participants with a diagnosis of HIV/AIDS.

Eligibility for the SPBP is determined by the following criteria:

Income Limits:	Individuals - \$30,000 gross income per year Families - \$30,000 gross income per year, plus an allowance of \$2,480 for each additional family member. (Example: family of two \$32,480 combined gross; family of three \$34,960 combined gross; etc.)
Residence:	Must be a Pennsylvania resident living in Pennsylvania/not institutionalized.
Medical Need:	Your physician must sign and date Section 10. You must submit a copy of at least one HIV/AIDS specific antiretroviral medication.
Resources:	Resources such as real property etc. are exempt.

### **YOU MUST SUBMIT COPIES OF THE FOLLOWING DOCUMENTATION WITH YOUR SPBP APPLICATION.**

- **PROOF OF RESIDENCE**
- **SOCIAL SECURITY CARD**
- **INCOME (INCLUDE PROOF FOR OTHER FAMILY MEMBERS IF APPLICABLE)**
- **YOUR PRESCRIPTION(S) FOR ANTIRETROVIRAL MEDICATION.**

**\* DO NOT SEND CASH REGISTER RECEIPTS, PHARMACY PRINTOUTS OR A HAND PRINTED LIST OF DRUGS. YOU AND YOUR PHYSICIAN MUST SIGN AND DATE THE APPLICATION (SECTION 9 AND 10).**

**YOUR ACCESS TO SPBP BENEFITS WILL BE DELAYED DUE TO INCOMPLETE OR MISSING INFORMATION.**

NOTE: If you are a **Medical Assistance (MA) Program recipient** who is eligible for Medicare Part A or Part B, you are **not** eligible for the SPBP and should not apply. SPBP applicants who are eligible for Medicare Part A or Part B, should enroll in Medicare Part D and apply to the SPBP to cover the cost sharing expenses such as premiums, co-payments and deductibles.

If you have other health insurance that pays for drugs, you should still apply for the SPBP. With most insurance drug policies, SPBP can reimburse appropriate providers for the portion of drug costs not covered by your policy or the copay.

## **ALL INFORMATION SUPPLIED TO THE SPBP COORDINATOR IS STRICTLY CONFIDENTIAL**

**Clients must advise SPBP Staff of any changes in address and/or income.**

The SPBP requires annual recertification. Clients will be notified by mail and asked to verify information.

**Important HIV/AIDS Drug Information from the Department of Public Welfare. Free interpretation services available.**

Información importante del Departamento de Bienestar Público sobre medicamentos para el VIH/SIDA. Ofrecemos servicios de interpretación sin cobro.

Важная информация Отдела социального обеспечения (Department of Public Welfare) о лекарствах против СПИДа/ВИЧ. Предоставляются услуги переводчика (бесплатно).

这是公共福利部关于艾滋病病毒 / 艾滋病 (HIV/AIDS) 药品的重要通知。可提供免费的翻译服务。

Thông tin quan trọng về Thuốc HIV/AIDS của Sở Trợ Cấp Phúc Lợi Công Cộng. Dịch vụ thông dịch được miễn phí.

ព័ត៌មានសំខាន់អំពីថ្នាំសំរាប់អាត អេដអាយវី/អេដស្យូ (HIV/AIDS) ចេញពី ការិយាល័យដំណើរការ។ មានការបំរើផ្នែកខាងបកប្រែដោយឥតគិតថ្លៃ។

- SECTION 1: Enter your full name, sex, and date of birth.
- SECTION 2: Enter your principal place of residence and provide proof with your application. The address on your application must match supporting proof. Some examples you may use for proof of residency are: phone/utility bill, social security award letter, driver's license, etc.
- SECTION 3: Enter your Social Security Number and provide a copy of your Social Security Card. Enter your spouse's Social Security Number, if applicable.
- SECTION 4: Enter your race. This information is optional.
- SECTION 5: Complete this section if you need another member of your household or someone outside your household to get your prescriptions for you. Enter the name, and telephone of that individual.
- SECTION 6: Provide information regarding your family composition if applicable. A family is spouses, children under 18 and parents of children under 18 who live together (NOTE: single/unmarried applicants over 18 with no dependents do not list household members.)
- SECTION 7: Indicate whether you have Medicare A (Hospital) and/or Medicare B (Medical), or Medicare D (Rx) coverage insurance. Indicate if you have other health insurance. Indicate the name and address of the insurance company.

Indicate if the insurance premiums are paid by your employer, union, yourself or other (if other-explain). If you pay your own premiums, indicate the cost per year. Indicate if your health insurance is a major medical plan or a supplement to Medicare. Indicate the amount of your annual deductible. Indicate the % of coverage for each prescription. If your plan pays 100% of prescriptions except a copay indicate the copay amount. If applicable indicate the copay for brand name drugs and generic drugs. (NOTE: If the policy holder is other than the applicant, indicate information in appropriate blocks.)

- SECTION 8: Please provide income information for yourself and each applicable member of your family. You must complete this section.

Financial eligibility will be determined based upon the gross income of the applicant/family. Gross income is income before deductions of income tax, employees Social Security taxes, etc.

**Proof of income must be provided.** For wage earners, proof should be provided by copies of pay stubs for the previous 30 days. If a pay stub is not available, a letter from the employer indicating gross pay for the last 30 calendar days should be sent.

Individuals who are self-employed should provide business records for the three months prior to application indicating the gross and net income.

Copies of unemployment checks, social security checks, pension checks, etc., or a benefit award letter should be provided as proof of other types of income. If you have zero income, you must provide documentation in the form of a support letter.

- SECTION 9: **SIGN AND DATE YOUR APPLICATION.**

- SECTION 10: **YOUR PHYSICIAN MUST SIGN AND DATE THIS SECTION AND INCLUDE HIS/HER LICENSE NUMBER.**

**Check the boxes below to be sure you have enclosed copies of:**

- |  |  |
|--|--|
| <input type="checkbox"/> <b>PROOF OF RESIDENCE</b>   | <input type="checkbox"/> <b>PROOF OF INCOME</b>  |
| <input type="checkbox"/> <b>SOCIAL SECURITY CARD</b> | <input type="checkbox"/> <b>HIV/AIDS SPECIFIC ANTIRETROVIRAL COVERED PRESCRIPTIONS</b> |
|  | <b>(Do not send pharmacy receipts or a hand printed list)</b>                          |

You must submit a copy of at least one HIV/AIDS specific antiretroviral medication prescription.

**YOUR ACCESS TO SPBP BENEFITS WILL BE DELAYED DUE TO INCOMPLETE OR MISSING INFORMATION.**

8. PROVIDE INCOME INFORMATION BELOW FOR YOURSELF AND EACH MEMBER OF YOUR FAMILY. GROSS INCOME SHOULD BE PROVIDED. INDIVIDUALS WHO ARE SELF-EMPLOYED MUST PROVIDE BUSINESS RECORDS FOR THREE MONTHS PRIOR TO APPLICATION, SO THAT INCOME MAY BE DETERMINED. PROOF OF INCOME IS REQUIRED. (SEE INSTRUCTIONS) **YOU MUST COMPLETE THIS SECTION.**

TYPE OF INCOME	PERSONS WHO RECEIVES INCOME	WEEKLY	OR	MONTHLY	ANNUAL AMOUNT
		GROSS INCOME		GROSS INCOME	
SALARY/WAGES/BONUSES/ COMMISSIONS (Before Deductions)	APPLICANT/SELF				
	SPOUSE (OR OTHER FAMILY)				
UNEMPLOYMENT BENEFITS					
VETERANS' BENEFITS					
SOCIAL SECURITY RETIREMENT/ SURVIVOR'S BENEFITS					
OTHER PENSIONS OR RETIREMENT					
SOCIAL SECURITY DISABILITY					
UNION BENEFITS					
WORKERS' COMPENSATION OR SICK BENEFITS					
OTHER DISABILITY INCOME					
ALIMONY OR CHILD SUPPORT					
DIVIDENDS/INTEREST/ROYALTIES					
RENTAL INCOME (GROSS MINUS EXPENSES)					
PUBLIC ASSISTANCE (NOT FOOD STAMPS AND LIHEAP)					
SUPPLEMENTAL SECURITY INCOME (SSI)					
OTHER INCOME					
<b>TOTAL</b>					

IF YOUR INCOME IS -0-, HAVE YOU APPLIED FOR MEDICAL ASSISTANCE?  YES  NO

IF YOUR INCOME IS -0-, HAVE YOU APPLIED FOR SOCIAL SECURITY?  YES  NO

**9. CERTIFICATION STATEMENT (MUST BE SIGNED AND DATED BY THE APPLICANT OR AUTHORIZED REPRESENTATIVE)**

I HEREBY CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I AM A PENNSYLVANIA RESIDENT CURRENTLY BEING TREATED FOR HIV/AIDS:

- This information is being given in connection with Commonwealth of Pennsylvania special funds.
- Program officials may verify the information on this form.
- I understand that if I deliberately misrepresent information on my application, I may be required to repay benefits and I may be prosecuted under applicable State and federal statutes.

**NOTE: THIS APPLICATION SHOULD BE SUBMITTED NO MORE THAN 30 DAYS AFTER YOU HAVE SIGNED AND DATED IT.**

\_\_\_\_\_  
SIGNATURE OF APPLICANT (or legal guardian, if patient is a minor)

\_\_\_\_\_  
DATE

**10. ATTESTATION STATEMENT (MUST BE SIGNED AND DATED BY A LICENSED PHYSICIAN)**

Based on my personal knowledge and evidence from the medical record, I certify that appropriate laboratory tests conclude the patient named in the application, has a diagnosis of HIV/AIDS. I understand that payments for specific HIV/AIDS medications will be sought from State and Federal funds under the Special Pharmaceutical Benefits Program. The misrepresentation, concealment, or falsification of information concerning the diagnosis of this applicant may subject the provider to civil or criminal sanctions.

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE

\_\_\_\_\_  
LICENSE NUMBER

\_\_\_\_\_  
DATE

**CLIENTS MUST ADVISE SPBP STAFF OF ANY CHANGES IN ADDRESS AND/OR INCOME.**

**ALL INFORMATION SUBMITTED IS CONFIDENTIAL AND WILL ONLY BE USED FOR THE PURPOSES OF THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM.**

**IF YOU NEED HELP COMPLETING THIS APPLICATION, PLEASE CALL 1-800-922-9384, or send an email to [SPBP@state.pa.us](mailto:SPBP@state.pa.us).**

**RETURN THE COMPLETED APPLICATION AND THE COPIES OF DOCUMENTATION TO:**

DEPARTMENT OF PUBLIC WELFARE  
SPECIAL PHARMACEUTICAL BENEFITS PROGRAM  
P.O. BOX 8021  
HARRISBURG, PENNSYLVANIA 17105-8021

**For more information go online to [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap) and click on HIV/AIDS**

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE**

**SPECIAL PHARMACEUTICAL BENEFITS APPLICATION**

1. NAME (Last, First, Middle Initial)		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH
2. STREET ADDRESS	APT. NO.	CITY	COUNTY STATE ZIP
3. YOUR SOCIAL SECURITY NUMBER	SPOUSE'S SOCIAL SECURITY NUMBER		HOME TELEPHONE NO. - OR NO. WHERE YOU CAN BE REACHED
4. RACE - OPTIONAL QUESTION <input type="checkbox"/> BLACK - Not Hispanic <input type="checkbox"/> HISPANIC <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN or PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN or ALASKAN NATIVE <input type="checkbox"/> OTHER			
5. AUTHORIZED REPRESENTATIVE: <input type="checkbox"/> Check this block if you need another member of your household or someone outside your household to get your prescription(s) for you.			
AUTHORIZED REPRESENTATIVE'S NAME: (Print)		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER
AUTHORIZED REPRESENTATIVE'S ADDRESS: (Print)			

6. FAMILY COMPOSITION - See Section 6 of the instructions					
NAME (Last, First, Middle Initial)	BIRTHDATE	SEX		SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU
		M	F		

**IF NEEDED, ATTACH A SEPARATE SHEET LISTING ADDITIONAL FAMILY MEMBERS.**

7. HEALTH INSURANCE INFORMATION	
DO YOU HAVE MEDICARE A (Hospital Insurance) <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE MEDICARE B (Medical Insurance) <input type="checkbox"/> YES <input type="checkbox"/> NO
DO YOU HAVE MEDICARE PART D <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU HAVE OTHER HEALTH INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE IDENTIFY BELOW:
NAME OF INSURANCE COMPANY	POLICY HOLDER NAME (if not applicant)
ADDRESS	POLICY HOLDER ADDRESS (if not applicant)
GROUP NUMBER/POLICY NUMBER	POLICY HOLDER SS# (if not applicant)
IS THIS HEALTH INSURANCE <input type="checkbox"/> A MAJOR MEDICAL PLAN <input type="checkbox"/> A SUPPLEMENT TO MEDICARE <input type="checkbox"/> OTHER	WHAT IS YOUR ANNUAL DEDUCTIBLE? \$ _____
INDICATE IF THE INSURANCE PREMIUMS ARE PAID BY: <input type="checkbox"/> EMPLOYER <input type="checkbox"/> UNION <input type="checkbox"/> SELF <input type="checkbox"/> OTHER (IF OTHER, EXPLAIN _____)	
IF YOU PAY YOUR OWN PREMIUMS, INDICATE THE TOTAL ANNUAL AMOUNT	\$ _____
IF YOUR PLAN COVERS PRESCRIPTIONS, WHAT PERCENTAGE IS COVERED? (ie. 50%, 80%, etc.)	% _____
IF YOUR PLAN COVERS PRESCRIPTIONS AT 100% EXCEPT CO-PAY, WHAT IS THE CO-PAY AMOUNT?	\$ _____
DO YOU PAY A DIFFERENT COPAY FOR BRAND NAME AND GENERIC DRUGS?	
BRAND NAME \$ _____	GENERIC \$ _____