COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

INSTRUCTIONS FOR COMPLETING THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM ENROLLMENT AND RE-ENROLLMENT 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 and specified laboratory tests for eligible participants with a diagnosis of HIV/AIDS.

Eligibility for the SPBP is determined by the following Criteria:

CRITERIA	NEW ENROLLMENT	RE-ENROLLMENT
*Income Limits:	Individuals - $37,642.90 gross income per year. Families - $37,642.90 gross income per year, plus an allowance of $13,345.20 for each additional family member. (Example: for a family of two the combined gross is $50,988.10).	Individuals - $55,850.00 gross income per year. Families - $55,850.00 gross income per year, plus an allowance of $19,800.00 for each additional family member. (Example: for a family of two the combined gross is $75,650.00).
Residence:	Must be a Pennsylvania resident living in Pennsylvania/not institutionalized.	Must be a Pennsylvania resident living in Pennsylvania/not institutionalized.
Medical Need:	Your prescribing clinician must sign and date Section 12.	Not required, this information already on record.
Resources:	Resources including real property are exempt.	Resources including real property are exempt.

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

NEW ENROLLMENT	RE-ENROLLMENT
⊡ Proof of Residence ⊡ Social Security Card ⊡ Income (INCLUDE PROOF FOR OTHER FAMILY MEMBERS IF APPLICABLE)	⊡ Proof of Residence ⊡ Social Security Card is not required, already on record. ⊡ Income (INCLUDE PROOF FOR OTHER FAMILY MEMBERS IF APPLICABLE)

NOTE: If you are a Medical Assistance (MA) Program Recipient receiving pharmaceutical benefits you are not eligible 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 many providers for the portion of drug costs not covered by your policy or the copay.

Clients must promptly advise SPBP Staff of any changes in address, insurance coverage and income.

THE SPBP REQUIRES ALL CLIENTS TO RE-ENROLL EVERY SIX MONTHS. CLIENTS WILL BE NOTIFIED BY MAIL EVERY SIX MONTHS TO COMPLETE A RE-ENROLLMENT APPLICATION AND VERIFY THEIR INFORMATION.

NOTE: It is imperative that all Clients re-enroll and maintain active benefits with the SPBP every six months. If you allow your benefits to be cancelled for failure to re-enroll, you will be required to submit a new enrollment application with the lower annual income ceiling.

*** Income limits are subject to change, please contact the SPBP for the most current income information.**

SECTION 1: FOR NEW & RE-ENROLLMENT: Enter your full legal name, sex, date of birth, language preference and if transgender check off appropriate box. For re-enrollment please provide your SPBP identification number.

SECTION 2: FOR NEW & RE-ENROLLMENT: 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: FOR NEW & RE-ENROLLMENT: Enter your Social Security Number and provide a copy of your Social Security Card. **If you do not have a Social Security Number you must check off box to inform us,** otherwise your application will be delayed awaiting proof of Social Security Number.

NOTE: You are not required to provide a copy of your Social Security Card for re-enrollment. We already have that copy in our records.

SECTION 4: FOR NEW & RE-ENROLLMENT: Enter your ethnicity and your race. This information is required.

SECTION 5: FOR NEW & RE-ENROLLMENT: You are required to answer the question about your Case Manager and provide all information in section 5. If you do not know your Case Manager's National Provider Identifier (NPI) please contact him/her and inquire. Your Case Manager may or may not have an NPI number.

SECTION 6: FOR NEW & RE-ENROLLMENT: You are required to provide all information in section 6 pertaining to your Prescribing Clinician.

SECTION 7: FOR NEW & RE-ENROLLMENT: Provide information regarding your family composition if applicable. A family is spouse, children under 21 and parents of children under 21 who live together (NOTE: single/unmarried applicants over 21 with no dependents do not list household members.)

SECTION 8: FOR NEW & RE-ENROLLMENT: Indicate whether you have Medicare A (Hospital) and/or Medicare B (Medical), or Medicare D (Rx), Medicare Advantage Plan (HMO), Medical Assistance or Medicaid, or US Veterans Administration coverage by checking off appropriate boxes. Indicate if you have other health insurance by checking off that box and writing the name of the other private insurance. You are required to make copies of all insurance identification cards (front and back) and submit those copies with your application; otherwise your application will be delayed.

SECTION 9: FOR NEW & RE-ENROLLMENT: You are required to provide income information for yourself and each member of your family.

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, health care premiums, etc.

Proof of income must be provided. For wage earners, proof should be provided by copies of current pay stubs for a one month period. If you are paid weekly, submit four (4) recent pay statements; for bi-weekly, submit two (2) recent pay statements. If the pay statements are not available, a letter from the employer on company letterhead indicating gross pay for a one month period should be sent.

Individuals who are self-employed should provide their most current tax return, including schedule C. The tax return must be signed even if filed electronically. Business records from a third party for a three month period, prior to the application may also be used. For questions or additional information call the SPBP staff at 1-800-922-9384.

For other income award letters should be provided as proof of other types of income such as unemployment compensation, social security, pensions, etc.

If you have zero income, you must provide a letter stating that you currently do not have any income and explaining how you are meeting your daily needs. The letter must be signed and dated.

SECTION 10: FOR NEW & RE-ENROLLMENT: Females are required to complete the pregnancy status section. Please answer question one and if appropriate answer question two regarding pregnancy.

SECTION 11: FOR NEW & RE-ENROLLMENT: READ THE CERTIFICATION STATEMENT THEN SIGN AND DATE YOUR APPLICATION.

SECTION 12: FOR NEW ENROLLMENT ONLY: YOUR PRESCRIBING CLINICIAN MUST SIGN AND DATE THIS SECTION AND INCLUDE HIS/HER NPI NUMBER.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
SPECIAL PHARMACEUTICAL BENEFITS PROGRAM

CHECK THIS BOX IF NEW ENROLLMENT ☐	CHECK THIS BOX IF RE-ENROLLMENT ☐	FOR RE-ENROLLMENT PROVIDE ID NUMBER BELOW SP

You are required to provide your legal name exactly as it appears on your Social Security Card.

1. LEGAL NAME (Last, First, Middle Initial, Suffix)	SEX: ☐ MALE ☐ FEMALE ☐ TRANSGENDER*	DATE OF BIRTH	LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

* If Transgender, please indicate one of the following: ☐ Male to Female ☐ Female to Male

Provide proof of your principal place of residence. The address on this application must match supporting proof. Some examples you may use for proof of your current residency are: phone/utility bill, Social Security award letter, Driver's License, etc.

2. STREET ADDRESS	APT. NO.	CITY	STATE	ZIP

3. YOUR SOCIAL SECURITY NUMBER	HOME TELEPHONE NUMBER	CELL PHONE NUMBER

A copy of your Social Security Card is required for new enrollment. If you do not have a Social Security number, please check this box. ☐

4. Check one box for your ethnicity and one box for your race. THIS INFORMATION IS REQUIRED.

ETHNICITY - Check one box ☐ HISPANIC/LATINO(A) ☐ NON-HISPANIC

RACE - Check one box ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN
☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN or ALASKA NATIVE ☐ OTHER_____

5. THIS INFORMATION IS REQUIRED. Do you have a Case Manager? ☐ YES ☐ NO If you do have a Case Manager, complete the information below.

NAME OF CASE MANAGER	NAME OF AGENCY	PROVIDE NPI# IF AVAILABLE

CASE MANAGER'S TELEPHONE NUMBER	ADDRESS OF AGENCY

6. THIS INFORMATION IS REQUIRED. Provide your Prescribing Clinician's information below.

PRESCRIBING CLINICIAN'S NAME	NAME OF HOSPITAL OR CLINIC	PRESCRIBER'S NPI NUMBER

PRESCRIBING CLINICIAN'S TELEPHONE NUMBER	ADDRESS OF HOSPITAL OR CLINIC

7. FAMILY COMPOSITION - Provide information for all family members (see instructions for SPBP definition of "family") who reside in the applicant's household. If needed, attach a separate sheet listing additional family members.

NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX)	DATE OF BIRTH	SEX			SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU
		M	F	T		

8. HEALTH PROGRAMS AND INSURANCE INFORMATION - Place a checkmark in the box or boxes below to indicate all health programs or private insurance in which you are enrolled. We require a copy of the front and back of all your membership ID cards.

☐ MEDICARE PART A ☐ MEDICARE PART B ☐ MEDICARE PART D (PRESCRIPTIONS)
☐ MEDICARE ADVANTAGE PLAN (HMO) ☐ MEDICAL ASSISTANCE OR MEDICAID ☐ US VETERANS ADMINISTRATION
☐ OTHER - WRITE THE NAME OF THE INSURANCE PLAN, NOT INCLUDED ABOVE, IN THE SPACE BELOW.

☐ PLEASE CHECK THIS BOX IF YOU DO NOT HAVE ANY OTHER MEDICAL, PRESCRIPTION, OR OTHER HEALTH COVERAGE OR INSURANCE.

REMEMBER TO PROVIDE COPIES OF ALL HEALTH INSURANCE PROGRAM ID CARDS FRONT & BACK OTHERWISE YOUR APPLICATION WILL BE DELAYED.

9. You must complete this section. Provide gross income information for yourself and each member of your family. Individuals who are self-employed please read instructions attached. If an individual has no income, indicate that with "0" on this application and provide a signed and dated letter stating you have zero income and how you are meeting your daily needs. **A MONTH'S WORTH OF GROSS INCOME IS REQUIRED.** If you are paid weekly, submit 4 recent pay statements; for bi-weekly, submit 2 recent pay statements. You may forward your most current tax return as verification. The tax returns must be signed.

TYPE OF INCOME	PERSONS WHO RECEIVE INCOME		WEEKLY GROSS INCOME	BI-WEEKLY GROSS INCOME	MONTHLY GROSS INCOME	ANNUAL AMOUNT
	APPLICANT SELF	SPOUSE OR OTHER FAMILY				
SALARY/WAGES/BONUSES/COMMISSIONS (BEFORE DEDUCTIONS)						
UNEMPLOYMENT OR VETERANS BENEFITS						
SOCIAL SECURITY RETIREMENT/SURVIVOR'S BENEFITS/SSI						
OTHER PENSIONS OR RETIREMENT						
SOCIAL SECURITY DISABILITY OR OTHER DISABILITY INCOME						
WORKER'S COMPENSATION OR SICK BENEFITS						
ALIMONY OR CHILD SUPPORT						
DIVIDENDS/INTEREST/ROYALTIES						
RENTAL INCOME (GROSS MINUS EXPENSES)						
PUBLIC ASSISTANCE (NOT FOOD STAMPS OR LIHEAP)						
BUSINESS/SELF EMPLOYMENT/PARTNERSHIPS						
TOTAL						

HAVE YOU APPLIED FOR MEDICAL ASSISTANCE IN THE LAST SIX (6) MONTHS? ☐ YES ☐ NO

10. PREGNANCY STATUS: (Females only - your response is required) Were you pregnant at any time during the last 6 months? ☐ YES ☐ NO
If pregnant within the last 6 months, did the pregnancy result in a live birth? ☐ YES ☐ NO ☐ STILL PREGNANT

11. 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.
- I have read and understand the responsibilities, benefits and privacy notice pages attached.

_____ _____
SIGNATURE OF APPLICANT (or legal guardian, if patient is a minor) DATE

12. ATTESTATION STATEMENT (MUST BE SIGNED AND DATED BY A LICENSED CLINICIAN) NOT REQUIRED FOR RE-ENROLLMENT

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 the applicant may subject the provider to civil or criminal sanctions.

_____ _____ _____
PRESCRIBING CLINICIAN'S SIGNATURE NPI NUMBER DATE

CLIENTS MUST ADVISE SPBP STAFF OF ANY CHANGES IN ADDRESS, INSURANCE AND/OR INCOME

ALL INFORMATION SUBMITTED WILL ONLY BE USED TO ADMINISTER THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM. IF YOU NEED HELP COMPLETING THIS APPLICATION, PLEASE CALL 1-800-922-9384, or send an email to SPBP@pa.gov

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

DEPARTMENT OF PUBLIC WELFARE
SPECIAL PHARMACEUTICAL BENEFITS PROGRAM
P.O. BOX 8808
HARRISBURG, PENNSYLVANIA 17105-8808
OR FAX THEM TO: (717) 651-3608

For more information go online to www.dpw.state.pa.us/foradults/healthcaremedicalassistance/index.htm, then click on Special Pharmaceutical Benefits.

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

SPECIAL PHARMACEUTICAL BENEFITS PROGRAM (SPBP) RESPONSIBILITIES & BENEFITS

RESPONSIBILITIES:

I understand that this application is a legal document and it is my responsibility to:

a. Comply with all SPBP policies as a condition of my continued eligibility.
b. Submit a re-enrollment application for review of my information every six months.
c. Update my address, insurance and income information with supporting documentation, when they occur.
d. Forgo and promptly send to the SPBP any payment from any insurance company for any amount which has been paid by the SPBP on my behalf.

BENEFITS:

Upon approval of your enrollment application you will have the following benefits:

a. Assistance with costs for SPBP formulary covered medications.
b. SPBP will assist with costs for SPBP specified laboratory services only if SPBP is Primary.
c. Annual assistance with Medicare Part D enrollment for SPBP Partnering Plans (if applicable).

APPEAL RIGHTS:

If your enrollment or re-enrollment application is denied or your benefits canceled, you have the right to appeal the decision and request a hearing.

PRIVACY NOTICE

You must give true, correct and complete information. You must cooperate in documenting or proving the information you give. Eligibility may be denied if you fail to provide certain verification.

We keep information you give confidential and use it only to administer the programs you apply for and/or may be eligible for. Information is shared with claim processing vendors for the purpose of paying pharmaceutical, laboratory claims if applicable and coordination of benefits.

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ទូរស័ព្ទ 1-866-872-8969 បើលោកអ្នកត្រូវការសំបុត្រនេះជាភាសាផ្សេងទៀត
ឬត្រូវការអ្នកបកប្រែ។ ការបកប្រែភាសាផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

此通知的重要信息是有关您获得药品的新规定。如果您需要该**通知译成其他语言或需要有人替你翻译，请致电**1-866-872-8969。**此服务是免费的**.

Данное уведомление содержит важную информацию о новых правилах получения лекарств. Звоните 1-866-872-8969, если оно вам нужно на другом языке или нужна помощь переводчика. И то и другое предоставляется бесплатно.

Este aviso contiene información importante acerca de las reglas nuevas para obtener su medicina. Llame al 1-866-872-8969 si necesita esto en otro idioma o si necesita un intérprete. El servicio es gratuito.

Thông báo này gồm những điều lệ mới quan trọng khi quí vị đi lấy thuốc. Cần bản tin này bằng thứ tiếng khác hay cần một thông dịch viên, xin quí vị gọi số 1-866-872-8969. Dịch vụ này được miễn phí.