COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE (DPW)

INSTRUCTIONS FOR COMPLETING THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM APPLICATION FOR ATYPICAL ANTIPSYCHOTIC MEDICATIONS

The Special Pharmaceutical Benefits Program for Mental Health (SPBP MH) is administered by the Pennsylvania Department of Public Welfare and provides payment for specific atypical antipsychotic medications for eligible participants.

If you wish to receive benefits through the SPBP, you must complete an application and submit it with **copies** of required documentation.

Eligibility for the SPBP is determined by the following criteria:

Income Limits:	Individuals - $35,000 gross income per year Families - $35,000 gross income per year, plus an allowance of $2,893 for each additional family member. (Example: family of two $37,893 combined gross; family of three $40,786 combined gross; etc.)
Residence:	Must be a Pennsylvania resident living in Pennsylvania/not institutionalized.
Medical Need:	Must have a medical need with a DSM diagnosis of schizophrenia. The prescription must include the DSM diagnosis, the ICD-9-CM diagnosis code number and the physician must sign and date the certification field on the back of this Application (Section 10).
Resources:	Resources such as real property, inheritance, 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 SCHIZOPHRENIA INCLUDING ICD-9-CM CODE NUMBER.**

*** 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: Medical Assistance (MA) Program **recipients who receive pharmaceutical coverage** through MA or a MA managed care provider are not eligible for a SPBP card, 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 outstanding expenses such as premiums, co-payments and deductibles for SPBP covered drugs.

If you have other health insurance that pays for drugs, you can still apply for the SPBP. If you are approved for SPBP, SPBP is the payer of last resort (other insurance carriers will be billed first).

ALL INFORMATION SUPPLIED TO THE SPBP COORDINATOR IS STRICTLY CONFIDENTIAL

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 1-877-356-5355, OR SEND AN EMAIL TO SPBPMH@state.pa.us.

RETURN THE COMPLETED APPLICATION AND THE COPIES OF DOCUMENTATION TO:

DEPARTMENT OF PUBLIC WELFARE
SPBPMH
P.O. BOX 2675
Admin ~~BEECHMONT~~ BUILDING ~~#32~~ # 11
HARRISBURG, PENNSYLVANIA 17105-2675

OR

FAX TO: ~~717-772-7964~~ 717 787-5394
ATTN: SPBPMH

For more information go online to www.dpw.state.pa.us/ServicesPrograms; go to Mental Health; click More; select SPBP MH.

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 taxes.

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 letter explaining how your daily needs are being met.

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:

- ☐ **PROOF OF RESIDENCE**
- ☐ **PROOF OF INCOME**
- ☐ **SOCIAL SECURITY CARD**
- ☐ **PRESCRIPTION FOR SCHIZOPHRENIA INCLUDING ICD-9-CM CODE #**

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

Detach this section and keep for your information.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE (DPW)

SPECIAL PHARMACEUTICAL BENEFITS APPLICATION FOR SPECIFIC ANTIPSYCHOTIC MEDICATIONS

(FOR SPECIFIC DSM DIAGNOSES OF SCHIZOPHRENIA)

1. NAME (Last, First, Middle Initial)			SEX ☐ MALE ☐ 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
☐ 1 BLACK - Not Hispanic ☐ 2 HISPANIC ☐ 3 WHITE ☐ 4 ASIAN or PACIFIC ISLANDER ☐ 5 AMERICAN INDIAN or ALASKAN NATIVE ☐ 6 OTHER

5. AUTHORIZED REPRESENTATIVE:
☐ 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 M	SEX F	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU

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

7. HEALTH INSURANCE INFORMATION
DO YOU HAVE MEDICARE A (Hospital Insurance) ☐ YES ☐ NO DO YOU HAVE MEDICARE B (Medical Insurance) ☐ YES ☐ NO DO YOU HAVE MEDICARE PART D ☐ YES ☐ NO

DO YOU HAVE OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ 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
☐ A MAJOR MEDICAL PLAN ☐ A SUPPLEMENT TO MEDICARE ☐ OTHER

WHAT IS YOUR ANNUAL DEDUCTIBLE? $_____

INDICATE IF THE INSURANCE PREMIUMS ARE PAID BY:
☐ EMPLOYER ☐ UNION ☐ SELF ☐ 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 $_____

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 GROSS INCOME	OR	MONTHLY GROSS INCOME	ANNUAL AMOUNT
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					
TOTAL					

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 SCHIZOPHRENIA:

- 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, I certify that the DSM diagnosis of schizophrenia as set forth on the enclosed prescription for this applicant is true and accurate. I understand that payment for specific atypical antipsychotic medications will be sought from state funds available 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.

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