GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DEPARTMENT OF HUMAN SERVICES

VI STATE PHARMACEUTICAL ASSISTANCE PROGRAM

PRESCRIPTION VERIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN ONLY)

NAME OF PATIENT

_____

*NAME OF GUARDIAN*_____

_____

IN CASE OF EMERGENCY CONTACT PARENTS

/OR _____*PHONE*

_____

DATE OF BIRTH

_____

HOME PHONE

_____

WORK PHONE

_____

FAMILY DOCTOR

_____

OFFICE PHONE

_____

Medical Insurance Plan No.:

_____

A. **Please note any health problem, physical handicap, emotional difficulty, behavioral problem, or facts which may limit full participation in our Sate Pharmaceutical Assistant Program.**

_____

_____

B. **Patient is subjected to allergies:**

YES (__) NO (__)

Codeine____ Sulfa_____ Aspirin_____ Other_____

C. **Patient is subject to:**

__ asthma	__ sensitive skin	__ sleepwalking	__ nosebleed
__ ear ache	__ sinus trouble	__ convulsions	__ high blood pressure
__ fainting	__ frequent colds	__ headache	__ motion sickness
__ tonsillitis	__ nightmares	__ bed wetting	__ allergies
__ eye infection	__ bronchitis	__ kidney problem	(describe)

D. Patient wears contact lenses (__) or glasses (___)

Medical Conditions and Diagnosis: (Check all that apply)
High Blood Pressure _____ Diabetes _____ Arthritis _____
Cancer _____ Heart Lung _____
Other _____
_____

E. To ensure that all patients comply with their medication regimen in a cost contained manner, please provide a list of the patient current list of medication prescribed by you and the indication of its use.

Medication	Strength (mg)	SIG Directions	Prescribing Doctor	Doctor Phone #	Pharmacy Company	Date

NOTE: THE SPAP PROVIDES MEDICATION ASSISTANCE TO SENIORS. TO ENSURE THAT WE PROVIDE ADEQUATE COVERAGE FOR OUR SENIORS, WE ENCOURAGE PHYSICIANS TO PRESCIBE GENERICS UNLESS BRAND IS ABSOLUTELY NECESSARY!!!

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SPAP APPLICATION

MEDICARE I.D HICN. # _____ DATE_____

NAME _____
Last First Initial

SOCIAL SECURITY #_____ DATE OF BIRTH_____ PLACE OF BIRTH _____

ADDRESS: (PHYSICAL) _____

(MAILING) _____

TELEPHONE NUMBER: (HOME) _____ (WORK) _____ (CELL) _____

CITIZENSHIP STATUS: A. Alien__ B. U.S. Citizen__ C. Resident Alien (Green Card) ___
ETHNICITY: A. Black____ B. Caucasian _____ C. Hispanic _____ D. Other _____
MARTIAL STATUS: Married___ Single___ Divorced___ Widowed___ Separated ____
NAME OF SPOUSE / CONTACT PERSON: _____
(H) _____ (W) _____ (CELL) _____

ADDRESS: _____

EMPLOYMENT STATUS:

A. Unemployed ___ B. Part-time employment___ C. Retired____ D. Full-time employment___
E. Are you interested in Employment? Yes____ No _____
Name of Employer _____

Address _____ Phone _____

HEALTH INSURANCE & PRESCRIPTION DRUG COVERAGE INFDORMATION:

PLEASE INDICATE CURRENT INSURANCE & PLAN. CIRCLE ALL THAT APPLY.

MEDICARE PART A MEDICARE PART B

MEDICARE PART D MEDICAID

OTHER_____ _____

IF OTHER INDICATED PLEASE SUBMIT A COPY OF YOUR CARD(S) WITH THIS APPLICATION

Please list current doctors and date last seen.

Doctor	Date Last Visited
_____	_____
_____	_____
_____	_____

What is the state of your health? Fair ___ Good ___ Excellent ____ Average___ Poor___

Do you have any ailments? _____
Do you have difficulties taking care of yourself? Yes ___ No ___

If yes, what are those difficulties? _____

_____

Please list medications that you are currently taking? _____

_____

What are your food/drug allergies? _____

_____

SERVICES RECEIVED/ NEEDED:

Mental Health Services ___ Home Delivered Meals___ Homemaker Services___
Home Health Care ___ Income Maintenance ___ Adult Protective Services___ Housing ___
Educational (U. V .I.) ___ Medical Assistance ____ Social Security ___ Food Stamps ___
Other _____

CERTIFICATION AND AUTHORIZATION

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND ACCURATE. I UNDERSTAND THAT IF I PROVIDE FALSE, FRAUDULENT OR MISLEADING INFORMATION, I FACE FINES AND PENALTIES UNDER VI LAW. I AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION, BANKING INSTITUTIONS, PRIVATE INSURANCE COMPANIES, AND OTHERS TO RELEASE INFORMATION NECESSARY TO DETERMINE MY VI SPAT ELIGIBILITY. I AUTHORIZE THE VI SPAP TO RELEASE INFORMATION ABOUT ME., IF APPLICABLE, AS NECESSARY FOR RECEPT OF VI SPAP BENEFITS AND MEDICAREPRESCRIPTION BENEFITS AND OR THE ADMINISTRATION OF THE VI SPAP PROGRAM, AS PERMISSIBLE BY FEDERAL OF LOCAL LAW. I FURTHER AUTHORIZE MY HEALTH CARE PROVIDER TO RELEASE ALL MEDICAL RECORD PERTAINING TO PRESCRIPTION COVERED BY VISAP TO ASSURE THAT THE SERVICES PAID FOR BY VI SPAP WERE APPROPRIATE.

APPLICANT SIGNATURE/MARK_____ DATE_____

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: _____

TELEPHONE: _____ E-MAIL:_____

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INCOME INFORMATION

Date_____

I.D. NUMBER_____

NAME OF CLIENT _____

INCOME INFORMATION:

Wages/Salary/ Tips $_____

Profit from Self Employment $ _____

Interest from Savings Accounts $ _____
Interest from Certificates of Deposits (CD'S) $ _____
Other Interest Income and Dividends _____

Pair Market Rental $ _____
Other In-kind Income $_____
_____
_____

Rental Income $ _____
Unemployment Insurance $_____
Workmen's Compensation $_____
Veteran's Compensation $_____
Social Security $_____
Pensions, Annuities &
Private Insurance $ _____
_____
_____
_____

TOTAL INCOME $ _____

CIVIL RIGHTS CLAUSE:

No person shall, on the grounds of race, color, sex or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this program.

Please be aware to recertify

I certify that the information given is true and correct.

Client's Signature: _____

Employee's Signature_____

Director's Signature _____