GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS

DEPARTMENT OF HUMAN SERVICES

VI STATE PHARMACEUTICAL ASSISTANCE PROGRAM

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 SPAP ELIGIBILITY. I AUTHORIZE THE VI SPAP TO RELEASE INFORMATION ABOUT ME., IF APPLICABLE, AS NECESSARY FOR RECEIPT OF VI SPAP BENEFITS AND MEDICARE PRESCRIPTION BENEFITS AND OR THE ADMINISTRATION OF THE VI SPAP PROGRAM, AS PERMISSIBLE BY FEDERAL OR LOCAL LAW. I FURTHER AUTHORIZE MY HEALTH CARE PROVIDER TO RELEASE ALL MEDICAL RECORDS PERTAINING TO PRESCRIPTIONS COVERED BY VISPAP 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:_____