



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 INFORMATION:

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 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: _____