



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

DATE OF BIRTH

NAME OF

HOME PHONE

*GUARDIAN*_____

WORK PHONE

IN CASE OF EMERGENCY CONTACT

FAMILY DOCTOR

PARENTS

/OR _____ *PHONE*

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 State Pharmaceutical Assistant Program.

B. Patient is subjected to allergies:

YES (___) NO (___)

Codeine_____ Sulfa_____ Aspirin_____ Other_____

C. Patient is subject to:

<input type="checkbox"/> asthma	<input type="checkbox"/> sensitive skin	<input type="checkbox"/> sleepwalking	<input type="checkbox"/> nosebleed
<input type="checkbox"/> ear ache	<input type="checkbox"/> sinus trouble	<input type="checkbox"/> convulsions	<input type="checkbox"/> high blood pressure
<input type="checkbox"/> fainting	<input type="checkbox"/> frequent colds	<input type="checkbox"/> headache	<input type="checkbox"/> motion sickness
<input type="checkbox"/> tonsillitis	<input type="checkbox"/> nightmares	<input type="checkbox"/> bed wetting	<input type="checkbox"/> allergies
<input type="checkbox"/> eye infection	<input type="checkbox"/> bronchitis	<input type="checkbox"/> 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 PRESCRIBE 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 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 SPAT ELIGIBILITY. I AUTHORIZE THE VI SPAP TO RELEASE INFORMATION ABOUT ME., IF APPLICABLE, AS NECESSARY FOR RECEIPT 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 _____