



The Special Pharmaceutical Benefits Program (SPBP) is administered by the Pennsylvania Department of Health. For more information regarding program eligibility requirements, income limits or covered services, go to www.health.pa.gov/spbp.

For questions about the application or enrolling, call 1-800-922-9384 or send your questions to SPBP@pa.gov.

1 Applicant Information				
Last name		First name		
Middle initial	Suffix (Sr., Jr., etc.)		Preferred language	English Spanish Other
SPBP ID number (if known)				
Home address		Include proof of residency with your application.		
City	State		Zip	
Provide your preferred mailing address below if it is different from your home address. It must be a Pennsylvania address.				
Preferred mailing address				
City		State		Zip
Date of birth				
Social Security number		Include proof of your Social Security number with your application.		
I do not have a Social Security number.				
Home phone number		Mobile phone number		
Sex at birth (check one)	Current gender (Check one.)			
Male	Male	Transgender male to female	Transgender unspecified	Unknown
Female	Female	Transgender female to male	Decline to respond	Other
Ethnicity (Check one or more.)		Race (Check one or more.)		
Hispanic or Latino/a (Select subgroup.)		Black or African-American		
Mexican, Mexican-American, or Chicano/a		White		
Puerto Rican		Asian (Select subgroup.)		
Cuban		Asian Indian	Chinese	Filipino
Other Hispanic, Latino/a, or Spanish Origin		Japanese	Korean	Vietnamese
Non-Hispanic		Other Asian		
		American Indian or Alaska Native		
		Native Hawaiian or Pacific Islander (Select subgroup.)		
		Native Hawaiian	Guamanian or Chamorro	
		Samoan	Other Pacific Islander	
		Other		
Has your CD4 count ever dropped below 200 cells/ μ l?		Yes	No	Not sure
If applicable, complete the following question.				
Were you pregnant at any time during the last six months?		Yes	No	

2 Other Health Care Coverage

Do you currently have any other health care coverage? Yes (Complete the insured section below and provide a copy of your insurance card with your application.)
No (Complete the uninsured section below.)

Insured section

Check each type of coverage that you currently have and provide a copy of the front and back of each insurance card:

Medicare Part A	U.S. Veterans Administration
Medicare Part B	Private insurance (Select subtype.)
Medicare Part C/Advantage plan (HMO)	Employer plan
Medicare Part D	Affordable Care Act (ACA) plan (www.healthcare.gov)
Medicaid/Medical Assistance	Self purchased directly from insurance company
Other (Write in plan name.)	

Does your insurance plan cover prescription medications? Yes No (If you have a separate prescription card, provide a copy of the front and back of each card.)

Uninsured section

If you do not have insurance, please check the reason why.

Non-citizen
Cannot afford the cost/premiums
I decided not to apply for other health care coverage.
Other

Have you applied to Medicaid in the last 12 months? Yes No

If yes, what is the status of your Medicaid application?
Approved
Denied (Provide the Medicaid denial notice with application.)
Application currently under review

3 Family Members

Provide information for all family members who live in your household. Family members include your spouse and your children under 21 who reside in the same household; if you are under 21, include your parents if you reside in the same household. (Note: If you are a single/unmarried applicant 21 or older without dependents, do not list any family members.)

Spouse/family member #1

Name (last, first, middle initial, suffix)				Date of birth
Social Security number	Current gender	Male Female Transgender	Relationship to you	Spouse Child under 21 Parent of child under 21

Family member #2

Name (last, first, middle initial, suffix)				Date of birth
Social Security number	Current gender	Male Female Transgender	Relationship to you	Child under 21 Parent of child under 21

Family member #3

Name (last, first, middle initial, suffix)				Date of birth
Social Security number	Current gender	Male Female Transgender	Relationship to you	Child under 21 Parent of child under 21

If necessary, attach a separate sheet listing additional family members.

4 Household Income

Check each type of income received by you and your family members in the same household. Family members include your spouse and your children under 21 who reside in the same household; if you are under 21, include your parents if you reside in the same household. (Note: If you are a single/unmarried applicant 21 or older without dependents, do not check any family members.)

Type of income	Income received		
	Self	Spouse	Family member(s)
1. Salary/wages/bonus/commissions (before deductions)			
2. Unemployment compensation or veterans benefits			
3. Social Security retirement/survivor's benefits/SSI			
4. Other pensions or retirement			
5. Social Security disability or other disability income			
6. Worker's compensation or sick benefits			
7. Alimony or child support			
8. Dividends/interest/royalties/capital gains			
9. Rental income (gross income minus expenses)			
10. Public assistance (Do not include food stamps or LIHEAP.)			
11. Business/self-employed/partnerships			

- Provide proof of income for yourself, spouse, and family member(s).
- Examples of acceptable proof of income for gross salary/wages:
 - Pay stubs for at least four weeks (one month) of income
 - Previous year IRS 1040, PA 40, PA 1000, or local tax return (Tax returns must be signed even if filed electronically.)
 - Previous year W-2 form
 - Wages for small jobs: A non-notarized letter is acceptable.
 - Letter from HUD (Housing and Urban Development)
 - Written letter/document from employer with four weeks (one month) of income
- For other types of income, such as unemployment compensation, Social Security, pensions, etc., submit a copy of the award letter or other official documentation as proof.
- If you are self-employed, you must provide a copy of your most recent signed IRS 1040 tax return, including Schedule C.
- If you do not receive any income, you must provide a letter stating that you currently do not have any income and explain how you meet your daily needs. The letter must be signed and dated.

5 Case Manager Information

If you have a case manager, complete this section.

Name of case manager Case manager phone number

Case manager email

Name of agency Address of agency

6 Authorization for Disclosure of HIV-Related Information to Specified Persons

SPBP will not communicate with anyone other than you or your health care professional (i.e., clinician or case manager) regarding your information, unless this document is completed.

List all individuals below that you grant consent for SPBP to communicate with.

1. I _____ (print applicant’s name) am applying or reapplying for benefits from the Special Pharmaceutical Benefits Program (SPBP) of the Department of Health.
2. I understand that SPBP may need information about me or may have to discuss my circumstances with me or other persons in order to determine whether or not I am eligible for benefits and to resolve issues regarding my participation in SPBP.
3. I understand that my information is or may be confidential information under the Confidentiality of HIV-Related Information Act.
4. I understand that in order for SPBP to have discussions about my circumstances or to exchange information about me with persons other than me or my health care provider and case manager, I will need to give SPBP and its staff permission to talk to those persons.
5. I understand that signing this document will provide that permission for six months, unless I tell SPBP I do not want them to continue talking with a specific person or unless I say that a specific event will cause me to withdraw my permission.
6. I understand I will need to sign a new authorization each time I reapply for the program.
7. I understand that SPBP will not discuss my circumstances with persons other than me or my health care provider and case manager without my permission given in a separate written document that complies with the Confidentiality of HIV-Related Information Act (35 P.S. sec. 7601 et seq.).

I authorize the Special Pharmaceutical Benefits Program of the Pennsylvania Department of Health and its affiliates (Department of Aging and Magellan Health Services) to disclose information related to my HIV status and my proposed or ongoing participation in the Special Pharmaceutical Benefits Program for the purpose of enrolling, reenrolling or obtaining benefits that are or may be due to me under that program to any of the following persons (if necessary, attach a separate sheet listing additional individuals):

Full name and title or name of organization, agency, etc.

#1

Address	Phone number	Email address
---------	--------------	---------------

Full name and title or name of organization, agency, etc.

#2

Address	Phone number	Email address
---------	--------------	---------------

Full name and title or name of organization, agency, etc.

#3

Address	Phone number	Email address
---------	--------------	---------------

This authorization may be withdrawn at any time before the actual disclosure takes place. This authorization will **expire six months from the date of my enrollment** or when I am no longer participating in the program, if I have not withdrawn it earlier.

I have read or someone has read and explained this authorization to me.

Print applicant’s name
(individual applying for SPBP)

SPBP ID number (if known)

SIGN HERE

Applicant’s signature
(or legal guardian)

Date

7

Certification Statement and Applicant's Signature**My responsibilities**

I understand that this application is a legal document and it is my responsibility to:

1. Comply with all SPBP policies as a condition of my continued eligibility;
2. Submit a reenrollment application for review of my information every six months;
3. Update my address, insurance and income information with supporting documentation when they occur;
4. Act in a professional and responsible manner when communicating with SPBP representatives; and
5. Forgo and promptly send to SPBP any payment from any insurance company for any amount which has been paid by the SPBP on my behalf.

I understand and agree that failure to abide by any aforementioned responsibilities will lead to termination or a declined application.

My benefits

Upon approval of this enrollment application I will have the following benefits:

1. Assistance with costs for SPBP formulary covered medications;
2. Assistance with costs for SPBP specified laboratory services only if I have no other insurance coverage; and
3. Assistance with Medicare Part C and Part D enrollment in SPBP partnering plans and monthly premiums (if applicable).

My appeal rights

If my enrollment or reenrollment application is denied or my benefits canceled, I have the right to appeal the decision. (Information on how to appeal an adverse decision will be provided by SPBP in a separate letter.)

I certify that the information I have given on this application is true, correct and complete. I agree to cooperate in documenting the information I have given or providing additional information to support my application as required by the department. I understand that my eligibility may be denied if I fail to provide accurate or complete information or fail to cooperate with the SPBP as requested. I further understand that the SPBP may terminate my eligibility at any time if the information I have provided is determined to be false or incomplete.

SIGN HERE

Applicant's signature
(or legal guardian)

Date

All information submitted will be kept confidential and will only be used to administer the Special Pharmaceutical Benefits Program. Information is shared with claim processing vendors for the purpose of paying pharmaceutical and laboratory claims, if applicable, and for coordination of benefits.

If you need help completing this application, please call 1-800-922-9384 or send an email to SPBP@pa.gov.

8 Confirmation of HIV Diagnosis by a Licensed Clinician

1. If this is your first time applying to SPBP, give this section to your licensed clinician to complete. Your clinician must include his/her printed name, NPI number, signature and date below.
2. This section does not need to be completed for applicants reenrolling in SPBP.

Applicant's name (printed)

SPBP ID number (if applicable)

Date of patient's last appointment

Based on my personal knowledge and evidence from the medical record, by providing my signature below, I certify that appropriate laboratory tests conclude the patient named in the application has a diagnosis of HIV. I understand that payments for specific HIV medications will be sought from state and federal funds under the Special Pharmaceutical Benefits Program. The misrepresentation, concealment or falsification of information concerning the diagnosis of the applicant may subject the provider to civil or criminal sanctions.

Prescribing clinician's name (printed)

NPI number

SIGN HERE

Prescribing clinician's signature

Date

All information submitted will only be used to administer the Special Pharmaceutical Benefits Program. If you have questions about completing this section, please call 1-800-922-9384 or send an email to SPBP@pa.gov.

Return the completed form to:
 Department of Health
 Special Pharmaceutical Benefits Program
 P.O. Box 8808
 Harrisburg, PA 17105-8808
 Or email to: SPBP@magellanhealth.com
 Or fax to: 888-656-0372

Application Checklist (additional information to submit to SPBP with your application)

Checklist for individuals enrolling in SPBP for the first time

Include proof of residency.
 Include a copy of Social Security card.
 Include a copy of the front and back of health/prescription insurance card(s) [if applicable].
 Include Medicaid denial notice (if applicable).
 Include proof of household income.
 Provide section 8 "Confirmation of HIV Diagnosis by a Licensed Clinician" form to prescribing clinician to complete, sign and return to SPBP.

Checklist for individuals reenrolling in SPBP

Include proof of residency.
 Include a copy of the front and back of health/prescription insurance card(s) and insurance termination notices (if applicable).
 Include Medicaid denial notice (if applicable).
 Include proof of household income.

Return the completed application and copies of documentation to:



pennsylvania
 DEPARTMENT OF HEALTH

Special Pharmaceutical Benefits Program
 P.O. Box 8808
 Harrisburg, PA 17105-8808
 Or email to: SPBP@magellanhealth.com
 Or fax to: 888-656-0372

End of SPBP application