pennsylvania
DEPARTMENT OF HEALTH

Bureau of Family Health
Cystic Fibrosis (CF), Spina Bifida (SB), and Metabolic Formula Program Application

It is important that you read and follow the instructions for each section of the application. This will assist in your application being processed accurately and promptly. The verification forms and documents listed below must be submitted with the application. Please submit photocopies of required documentation. **DO NOT** send originals, as they will not be returned. If you have any questions or need assistance in completing the application, please call 717-783-8143.

Print clearly with blue or black ink – all dates must contain the month, day and four-digit year.

Section A. Applicant Information – Proof of residency and citizenship is required. Documents may not be more than two years old for proof of residency (i.e., IRS #1040, Pa driver's license, utility receipts, etc.), and citizenship (i.e., applicant's birth certificate or U.S. Citizenship and Immigration Services documents, etc.)

LAST NAME	SUFFIX (i.e., Jr., etc.)	FIRST NAME	MI	SOCIAL SECURITY NUMBER
				- -

ADDRESS (House number and Street, P.O. Box, Apt. #, etc.)	LENGTH OF TIME AT THIS ADDRESS

CITY	STATE	ZIP CODE (+4)	COUNTY

HOME TELEPHONE NUMBER	ALIAS, MAIDEN NAME OR OTHER NAME PREVIOUSLY USED TO RECEIVE SERVICES

Have you or a family member ever received services from the Bureau of Family Health? ☐ Yes ☐ No

If Yes, name of individual receiving services: ________________________________ Date services last received: _______________________

DATE OF BIRTH (MM/DD/CCYY): ______________________________

SEX: ☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ SELF-DESCRIBE **CITIZENSHIP:** ☐ U.S. CITIZEN ☐ LEGAL ALIEN ☐ OTHER

ETHNICITY (OPTIONAL): ☐ HISPANIC ORIGIN ☐ NOT OF HISPANIC ORIGIN ☐ UNKNOWN

RACE (OPTIONAL): ☐ AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ ASIAN (INDIAN SUBCONTINENT) ☐ CAUCASIAN ☐ NATIVE HAWAIIAN/PACIFIC ISLANDER ☐ OTHER/MULTI-RACIAL ☐ UNKNOWN

Section B. Applicant's Condition(s) – Attach a completed physician's statement, which is included as Attachment 2 to this application.

☐ CYSTIC FIBROSIS ☐ SPINA BIFIDA ☐ PKU/MSUD (METABOLIC FORMULA)

Section C. Health Insurance Information – If Yes is selected, the Health Insurance and Benefits Information Sheet, Attachment 3 to this application must be completed and attached to the application along with photocopies of all insurance and health care benefit cards.

DOES APPLICANT HAVE HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

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Section D. Parent/Court-Appointed Guardian/Attorney-In-Fact Information – Complete this section with the parent's/court-appointed guardian's/attorney-in-fact's information if the applicant is under 18 years of age and not emancipated, has a court-appointed guardian or an attorney-in-fact. Complete address and phone number information only if different from applicant. Power of attorney or guardianship verification must accompany the application when signed by the attorney-in-fact or court-appointed guardian.

LAST NAME | SUFFIX (i.e., Jr., etc.) | FIRST NAME | MI

ADDRESS (House number and Street, P.O. Box, Apt. #, etc.) | RELATIONSHIP TO APPLICANT

CITY | STATE | ZIP CODE (+4) | TELEPHONE NUMBER

Section E. **Applicant's/Household's Financial Information –** All Applicants/Households must complete items 1 through 7. Applicants must attach signed photocopies of the applicant's or household's most recent federal income tax form (IRS #1040), including tax schedules or other documents (i.e., SSA 1099, etc.) to verify the previous calendar year's income. If you have indicated no income, please attach an explanation of how your daily living expenses are being paid.

Previous year's income: ______ Number of individuals residing in your household during the previous year: ______

1. Total previous year's salary, wages, bonuses, commissions, income from self-employment and partnership income (Do not subtract losses from total income.) ______
2. Total previous year's gross pensions, annuities, veterans' and railroad retirement benefits and taxable portion of individual retirement accounts (IRAs) ______
3. Total previous year's gross Social Security and supplemental security income (Medicare premiums must be included.) ______
4. Total previous year's interest, dividends, capital gains, prizes (Do not subtract losses.) ______
5. Total previous year's net rental income received and net business income (Do not include rent you paid; do not subtract losses from your total income.) ______
6. Total previous year's other income [DPW Cash Assistance Program, unemployment or worker's compensation, alimony, support money, gifts totaling more than $300.00, death benefit payments exceeding $5,000.00 per person, court awards or financial settlements received (Note – If a court award or financial settlement is pending, submit a copy of the documentation.)] ______
7. TOTAL (Add lines 1 through 6.) ANNUAL FIGURE ______

Section F. By signing, I acknowledge that I have read the "Certification and Authorization Statements" Attachment 1 of this application and agree to the terms as stated, that I have lived in Pennsylvania for at least 90 days or intend to maintain a permanent home in Pennsylvania, and that the income information and all other information listed is true, correct and complete to the best of my knowledge. I have attached all required documentation with this application.

APPLICANT'S PARENT'S (if applicant is a minor)/AUTHORIZED REPRESENTATIVE/COURT-APPOINTED GUARDIAN'S/ATTORNEY-IN-FACT'S/WITNESS OR PREPARER'S SIGNATURE | DATE (MM/DD/CCYY)

FOR DEPARTMENT USE ONLY				
Date received	**Date rated**	**Applicant's eligibility date**	**Eligibility expiration date**	**Rater's initials**

The application, photocopies of the required documents and the required attachments should be returned to: Pennsylvania Department of Health, Bureau of Family Health, 7th Floor East Wing, 625 Forster St., Harrisburg, PA 17120, Attn: Newborn Screening

Attachment 1

Bureau of Family Health
Cystic Fibrosis (CF), Spina Bifida (SB), and Metabolic Formula Program Application
Certification and Authorization Statements

I understand that my signature on the application indicates my agreement to the following provisions:

A. I authorize the Department of Health or its authorized representative to verify any information on the application by contacting employers, appropriate agencies or others, as the need arises.

B. I authorize the Department of Health or its authorized representative to visit my residence with reasonable prior notice to me, for the purpose of determining the validity of information provided on the application or any claims made to the Bureau of Family Health (Bureau).

C. I understand that the Department of Health or its authorized representative, within its discretion, may release any relevant information in my Bureau file with the exception of HIV or drug and alcohol-related information to my treatment center or pharmacy for the purpose of verifying enrollment. I authorize such release of information.

D. I hereby assign the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to benefits to which I may be entitled under any other plan of government assistance or insurance from any for-profit third party insurer.

E. I hereby waive the confidentiality of information found in any third party insurer's file, except for HIV or drug and alcohol-related information, as witnessed by my signature on this application. I authorize the release of such information to my treatment center or pharmacy for the purpose of verifying enrollment.

F. I agree that I will not seek payment from the Department of Health for any amount of Bureau benefits which have been paid by any other plan of government assistance or insurance from any for-profit third party insurer on my behalf.

G. I understand that if it is determined that Bureau benefits have been paid improperly, I shall be required to repay such benefits. I authorize such collection from myself, my heirs, my agents and my personal representatives.

H. I understand that any person who submits a false or fraudulent claim or application to the Bureau, or who aids and abets another in the submission of a false or fraudulent claim or application or who claims and receives duplicate benefits may be charged with a criminal offense under 18 Pa. C.S. (relating to the Crimes Code).

I. I understand that the Department of Health or its representative's adverse actions against any applicant are subject to the right of appeal in accordance with the provisions of 1 Pa. Code, Part II. Adverse actions shall not include any determination with respect to individuals receiving metabolic formula.

J. I understand the Department of Health or its authorized representative may contact my physicians for relevant medical history and information related to my Bureau qualifying condition. I waive the confidentiality of such medical records and authorize such release to the Bureau, except as to HIV or drug and alcohol-related information.

K. I authorize the Internal Revenue Service, Pennsylvania Department of Revenue or the U.S. Railroad Retirement Board to release a copy of my income tax return or retirement income to the Department of Health or its authorized representative to verify my eligibility.

L. I understand that the Bureau may refer me to another agency to obtain health care benefits (i.e. Medical Assistance, CHIP), if appropriate.

Attachment 2

Bureau of Family Health
Cystic Fibrosis (CF), Spina Bifida (SB), and Metabolic Formula Program Application
Physician's Statement

Applicant's Name: ________________________________ Applicant's Social Security Number: ___________________

C O N F I D E N T I A L

NOTE: This form must be completed and signed by the attending physician who is treating the applicant for the applicable condition(s), and submitted with the Application. Only use this form for the conditions listed below.

Condition(s): ☐ CYSTIC FIBROSIS ☐ SPINA BIFIDA ☐ PKU/MSUD

Diagnosis (ICD-10-CM) Code Related to the Condition(s) checked above - Diagnostic Description

1. ☐☐☐.☐☐____________________________________ **2.** ☐☐☐.☐☐ ______________________________________

____

Has there been any change in the patient's condition since the last examination/appointment? ☐ YES ☐ NO
If yes, please explain.

Complete For PKU Only

Name of Formula: _____________________________________ Flavor: _____________________________________

If Applicant is over 22 years of age:

☐ **Applicant is over 22 years of age and is pregnant.**
Anticipated extent of time formula will be required (months)______________________

☐ **Applicant is over 22 years of age and is currently pursuing pregnancy.**
Anticipated extent of time formula will be required (months)______________________

Physician Information

Do you anticipate the condition(s) checked above will require medical treatment/services which will extend beyond twelve months? ☐ YES ☐ NO If Yes, approximately how long? ______________________________

Physician's Last Name: ______________________________ First Name: ____________________ Middle Initial:_____

Physician's License/Certification #: ______________________________ Telephone Number: _____________________

Physician's Practice Name: ____

Physician's Practice Address: ____

Physician's Practice City: ______________________________ State:_________________ Zip Code: _______________

I certify that the narrative description(s) of the applicant's diagnosis(es) are complete, as written, and accurate to the best of my knowledge, and I have obtained appropriate written consent for the disclosure of this medical information, including written consent for the disclosure of any HIV-related information as set forth in Section 7607 of the Confidentiality of HIV-Related Information Act, 35 P.S. Section 7601 et seq.

____ ______________________

PHYSICIAN'S SIGNATURE DATE (month/day/4 digit year)

Bureau of Family Health
Cystic Fibrosis (CF), Spina Bifida (SB), and Metabolic Formula Program
Health Insurance and Benefits Information Sheet

Applicant's Name: ________________________________ Applicant's Social Security Number: ________________________

NOTE: You must enclose photocopies of all insurance and benefits coverage cards with your application. If the applicant is receiving Medical Assistance (MA) services, you must provide a copy of the MA - Client Notice form PAFS 162 and enter MA/ACCESS ID # ____

PRIMARY HEALTH INSURANCE AND OTHER HEALTH BENEFITS COVERAGE FOR THE APPLICANT

________________________________ ______________________ _____ ______________________________
POLICYHOLDER'S LAST NAME, SUFFIX FIRST NAME MI. POLICYHOLDER'S SOCIAL SECURITY NUMBER

RELATIONSHIP TO THE APPLICANT: ☐ FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER, Describe__________________________

TYPE OF HEALTH INSURANCE AND BENEFITS COVERAGE **(Check All That Apply)**

☐ Basic Insurance ☐ HMO/POS/PPO ☐ Major Medical ☐ Dental Plan ☐ Prescription Drug Plan

____ __________________ to __________________
NAME OF INSURANCE COMPANY/OR BENEFIT PROGRAM COVERAGE PERIOD

____________________ _______________________ ______________________
POLICY NUMBER GROUP NUMBER PLAN NUMBER

OTHER INSURANCE PROGRAMS **COVERAGE PERIOD**

☐ Children's Health Insurance Program (CHIP) ____________________ to ____________________
☐ Medical Assistance (MA) ____________________ to ____________________
☐ Medicare A ____________________ to ____________________
☐ Medicare B ____________________ to ____________________
☐ Women, Infants & Children (WIC) ____________________ to ____________________
☐ Other (Describe) ______________________ ____________________ to ____________________

SECONDARY HEALTH INSURANCE AND OTHER HEALTH BENEFITS COVERAGE FOR THE APPLICANT

________________________________ ______________________ _____ ______________________________
POLICYHOLDER'S LAST NAME, SUFFIX FIRST NAME MI. POLICYHOLDER'S SOCIAL SECURITY NUMBER

RELATIONSHIP TO THE APPLICANT: ☐ FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER, Describe__________________________

TYPE OF HEALTH INSURANCE AND BENEFITS COVERAGE **(Check All That Apply)**

☐ Basic Insurance ☐ HMO/POS/PPO ☐ Major Medical ☐ Dental Plan ☐ Prescription Drug Plan

____ __________________ to __________________
NAME OF INSURANCE COMPANY/OR BENEFIT PROGRAM COVERAGE PERIOD

____________________ _______________________ ______________________
POLICY NUMBER GROUP NUMBER PLAN NUMBER

OTHER INSURANCE PROGRAMS **COVERAGE PERIOD**

☐ Children's Health Insurance Program (CHIP) ____________________ to ____________________
☐ Medical Assistance (MA) ____________________ to ____________________
☐ Medicare A ____________________ to ____________________
☐ Medicare B ____________________ to ____________________
☐ Women, Infants & Children (WIC) ____________________ to ____________________
☐ Other (Describe) ______________________ ____________________ to ____________________

NOTE: If more space is needed for insurance & benefit information, use the other side of this sheet.