DELAWARE **Prescription Assistance** PROGRAM
A prescription for better health

DXC DPAP
P.O. BOX 950
NEW CASTLE DE
19720-0950

Please complete and sign this form and return it **using the self-addressed envelope.** Your eligibility for this program cannot be determined unless your application is signed and copies of all documents requested are attached.

1. Applicant Name/Address

First Name	MI	Last Name	Social Security Number	Date of Birth
			- -	/ /

Street	Apt.	City	Zip	County	Phone Number
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Race (optional)	Sex	Marital Status	US Citizen
□ Black/African American □ White	□ Male	□ Married □ Divorced	□ Yes
□ Hispanic □ Asian □ Other	□ Female	□ Widowed □ Separated □ Never Married	□ No

Do you receive:

Social Security Disability Benefits? ☐ No ☐ Yes List Amount:
Other income: ☐ No ☐ Yes How often: List Amount:
Do you have Medicare? ☐ No ☐ Yes
Do you receive Extra help from Social Security? ☐ No ☐ Yes
Other pharmacy coverage or Medicare Part D coverage? ☐ No ☐ Yes Please send a copy of your card, or the name of your plan. 1) Name of Plan:_____

2. Income Documentation (or proof) must be provided with this application.
Return the original application with photocopies of income documents that apply to you. Examples include Social Security, Social Security Disability benefit, Veterans Benefit, pension, earnings, interest on saving and/or investments, cash given to you or any other income must be reported. If you are married, you <u>each</u> must complete a form. Mail both applications and all documentation in the same envelope.

Rights and Responsibilities

I have read or have read to me all of the statements on this form and the information I give is true and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

I understand that all information I give is confidential and federal and state laws limit disclosure of information about me.

I understand and agree to give proof of my statements. I understand that the Department of Health and Social Services may contact other persons or organizations to obtain the necessary proof of my eligibility.

I certify, under penalty of perjury, that I am a U.S. citizen or Alien in lawful immigration status. I must give proof of lawful immigration status and it will be checked with the U.S. Citizenship and Immigration Services.

_____ _____
Signature of Applicant or Representative Date
If representative, please print name, relationship and phone number.

Name: _____ Relationship: _____ Phone: _____

The Delaware Prescription Assistance Program may help you pay for your prescriptions if you are a resident of Delaware and:

- Age 65 or over **or**
- Under age 65, but receiving Social Security Disability benefits **and**
- Have income under 200% of the Federal Poverty level **or**
  Have a yearly drug cost of more than 40% of you income.
- Enrolled in a Medicare Prescription Drug Plan (if you have Medicare)

The program will pay up to $3000 per person each benefit year. Co-pays are 25% or a minimum of $5.00. **We do not pay for mail order drugs.**

You are not eligible if you:

- Are eligible for full Medicaid benefits
- Have a health insurance policy, other than a Medicare Prescription Drug Plan, that gives you prescription drug coverage.

To apply, you must send us copies of the following items:

- Proof of income (check stubs, award letters)
- If not a citizen of the USA, proof of lawful resident status
- Proof of disability, if under age 65
- If eligible for Medicare, you must enroll with a Medicare Prescription Drug Plan and show proof of enrollment.
- You must apply for extra help with Social Security and show proof of approval or denial

Did you include:

- Signed application
- Copy of your PDP card
- All income documents
- Extra help letter

Return original completed application and additional documents to:

DXC DPAP
P.O. BOX 950
NEW CASTLE DE
19720-0950

Call the DPAP Member service representatives if you have any questions.
Monday through Friday
From 8:00 a.m. to 4:30 p.m.

1-800-996-9969

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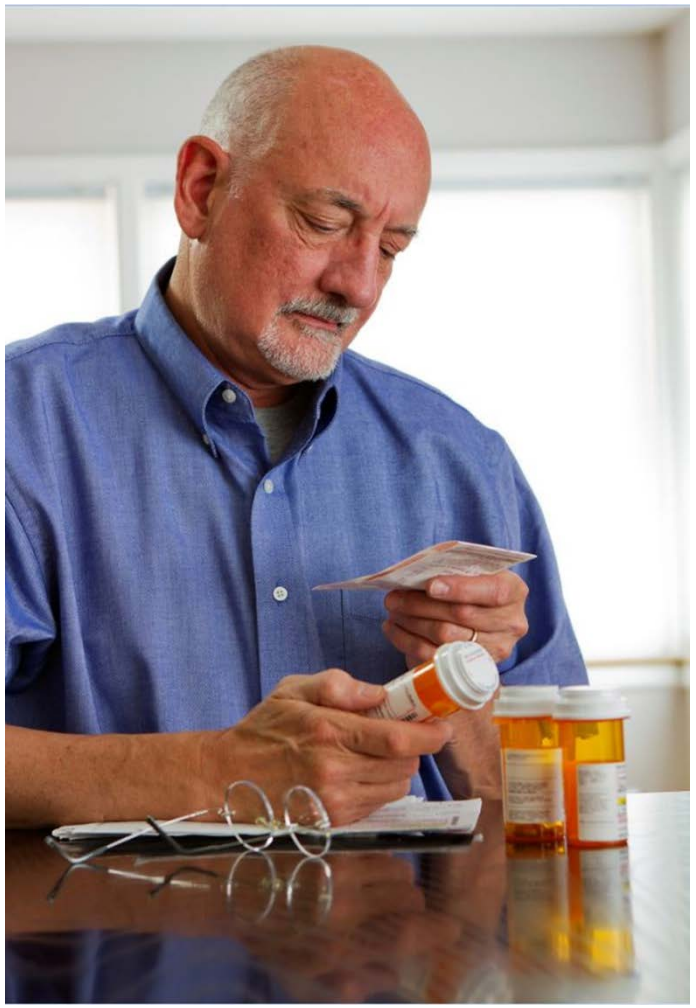

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