DELAWARE **Prescription Assistance** PROGRAM

A prescription for better health

EDS DPAP
P.O. Box 950
New Castle DE
19720-9914

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
			19	N K S	(302) -

Race (Optional)	Sex	Marital Status	US Citizen
☐ Black/African American ☐ White ☐ Hispanic ☐ Asian ☐ Other	☐ Male ☐ Female	☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married	☐ Yes ☐ No

Do you receive:

Extra Help from Social Security?	Social Security Disability Benefits?	Medicare?	Other Income?	Other Pharmacy Coverage?
☐ Yes ☐ No	☐ Yes ☐ No List Amount: _____	☐ Yes ☐ No	☐ Yes ☐ No How Often: _____ List Amount: _____	☐ Yes If Yes, please send a copy of your card. ☐ No Name of Plan: Phone Number:

2. Income Documentation (or proof) must be provided with this application.

Please return the original application with photocopies of supporting documents. Social Security, Social Security Disability Benefit, Veterans Benefit, pension, earnings, interest on savings and/or investments, cash given to you or any other income must be reported. Married couples fill out separate form. Mail both applications and all documentation in the same envelope.

Rights and Responsibilities

I have read or have had 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 Heath 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 immigration and naturalization service.

_____ _____

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

Date

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 your income.
- Enrolled in a Medicare Prescription Drug Plan (if you have Medicare)

The program will pay up to $2500 per person each benefit year. There is a co-pay of 25% of the prescription cost with a minimum of $5.00.

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:

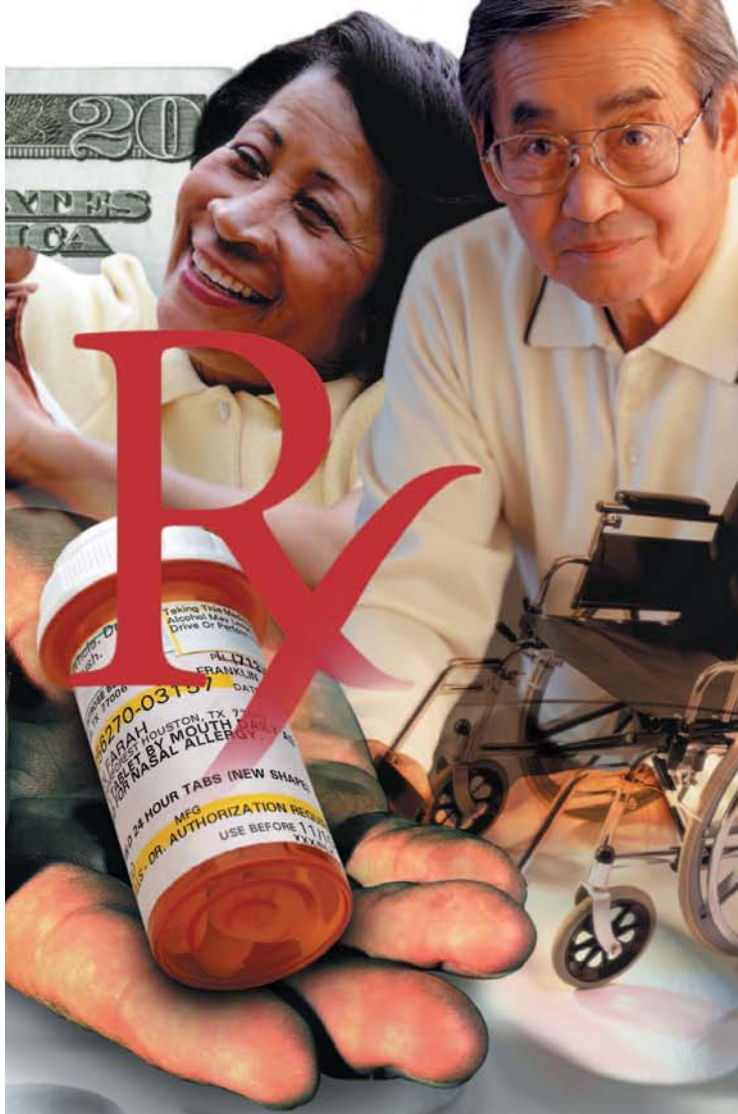
- Proof of income (check stubs, award letters)
- If not a citizen of the USA, proof of lawful resident status
- Proof of disability, if applicable
- If eligible for Medicare, you must enroll with a Medicare Prescription Drug plan and show proof of enrollment.
- If you may be eligible for the extra help,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

Call the DPAP customer service representatives.
Monday through Friday
From 8:00 a.m. to 4:30 p.m.

1-800-996-9969 (Option #2)

Return original completed application and additional documents to:

EDS DPAP
P.O. Box 950
New Castle DE
19720-9914



DELAWARE Prescription Assistance PROGRAM

A prescription for better health