Enrollment -Texas HIV State Pharmacy Assistance Program

TEXAS Department of State Health Services
Phone: 1-800-255-1090
Fax: 512-371-4670

Mailing Address: Texas Department of State Health Services
ATTN: MSJA - MC 1873
PO Box 149347
Austin, TX 78714-9347

Applicants with MEDICARE should fill out this form. Individuals with Medicare who are eligible for assistance from the Texas HIV Medication Program (THMP) will be enrolled in the HIV State Pharmacy Assistance Program (SPAP) to obtain their medications. The SPAP is designed to provide help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. If you have questions about the SPAP or this application please call 1-800-255-1090. **If you are not already enrolled in the THMP, you must also fill out the full THMP application.**

SECTION I – PERSONAL INFORMATION

Last Name	First Name	Middle Name

Mailing Address	Phone Number (area code + number)
	May we leave a message on your voice mail or answering machine? ☐ Yes ☐ No

Your Social Security Number	Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)

SECTION II – MEDICARE PRESCRIPTION DRUG INFORMATION

Are you enrolled in a Medicare Prescription Drug Plan (Part D)? ☐ Yes ☐ No if yes, please provide plan information below.

Plan Name:	Effective Date:

ID Number:	RxBin:	RxPCN:	RxGroup:

SECTION III – LOW INCOME SUBSIDY

Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration?

☐ Yes - please indicate application status below.
☐ No - you need to apply for this assistance, please call 1-800-255-1090 to have an application mailed to you.

Low Income Subsidy/Extra Help Application Status

☐ Approved, 100% Assistance
☐ Approved, partial assistance (attach copy of approval letter)
☐ Denied Assistance (attach a copy of pre-decisional or denial letter)
☐ Awaiting determination, application date:_____

SECTION IV – SPAP AGREEMENT

1) I understand that it is my responsibility to:
   a) enroll in a Medicare Prescription Drug Plan,
   b) maintain my enrollment in a Medicare Prescription Drug Plan, and
   c) pay the monthly prescription drug plan premium directly to the prescription drug plan.
2) I understand that it is my responsibility to notify the Texas HIV SPAP immediately if any of the following happen:
   a) my household income increases,
   b) my address changes or I move out of the State of Texas,
   c) my marital, household or insurance status changes, or
   d) my Medicare benefits are terminated.
3) I understand that the Texas HIV SPAP reserves the right to limit enrollment based upon availability of funds.
4) I understand that the Texas HIV SPAP is required to recertify my eligibility status every other year per program rules in order to continue receiving services.
5) I understand that this is a legal document. My signature (1) attests that all the information given is true and correct, (2) authorizes the release of my medical information to the Texas HIV Medication Program, including the Texas HIV SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant	Date
Signature of Parent (if applicant is under 18)	Date