



OFFICIAL USE ONLY
Date Received: _____
Case No.: _____

## State Pharmacy Assistance Program Application

Purpose:  New Application  Reporting Change

### Please Type or Print Clearly

#### 1. Please tell us who you are and where you live. Please use legal names and write legibly.

Last Name		First Name		Middle Initial		Birthdate (month/day/ year)	
Address (Where you live)			Apartment Number	City, State, and Zip Code		Daytime Phone Number	Nighttime Phone Number
Mailing Address (If it is different from where you live)				City, State, and Zip Code		E-Mail Address	

2. Are you a resident of the State of Hawaii?  Yes  No
3. Are you and/or your spouse receiving Social Security Benefits and/or retirement income?  Yes  No  
If yes, list name and amount of monthly gross Social Security benefit(s) \_\_\_\_\_ and/or monthly gross retirement income \_\_\_\_\_.
4. Are you and/or your spouse working?  Yes  No
5. Are you receiving drug coverage from a retirement plan other than Medicare Part D?  Yes  No
6. Are you receiving public assistance prescription drug coverage other than Medicare?  Yes  No  
If yes, which retirement plan? \_\_\_\_\_
7. Are you enrolled in a private sector plan/insurance that provides payment for prescription drugs:  Yes  No
8. Please check the Medicare Part D plan that you are enrolled in:

#### Medicare Part D Plans That ARE Eligible For 2011 SPAP

Plan Name	Plan ID #
<b>Stand Alone Part D Plans</b>	
AARP MedicareRx Preferred	(S5820-032)
Advantage Star Plan by RxAmerica	(S5644-085)
CVS Caremark Value (new name for SilverScript Value)	(S5601-066)
HealthSpring Prescription Drug Plan 33	(S5932-032)
Humana Walmart-Preferred Rx Plan	(S5884-115)
Medicare Rx Rewards Standard	(S5960-139)
<b>Combined Part C (managed care) and Part D Plans</b>	
AARP MedicareComp Choice	(H5424-001)
Akamai Advantage by HMSA - Secure	(R7439-001)
Akamai Advantage by HMSA - Select	(H3832-001)
AlohaCare Advantage	(H5969-001)
AlohaCare Advantage Plus	(H5969-002)
Evercare Plan DP*	(H5424-005)
Evercare Plan RDP	(R3175-003)
HMSA 65C+ Basic Option BRx	(H1251-003)
Humana Gold Choice	(H8145-073)
Humana Choice -001	(H0248-001)
Humana Choice -002	(H0248-002)
Kaiser Permanente Senior Advantage Basic	(H1230-003)
Kaiser Permanente Senior Advantage Enhanced	(H1230-001)
Ohana Liberty	(H2491-004)
Ohana Reserve	(H2491-001)
Ohana Value	(H2491-002)
SecureHorizons MedicareComplete Choice	(R3175-001)
Other (list):	

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**9. Please tell us ALL income your household got in the last TWELVE (12) months (before deductions-not take home pay) \$\_\_\_\_\_.** Household members are family members who are responsible for each other, such as a spouse and dependent children under 19 years old. You have \_\_\_\_\_ family members in your household.

Income can be wages, self-employment income (after business expenses), Social Security benefits, pension/retirement income, veteran's benefits, temporary disability insurance (TDI), workers compensation, unemployment insurance benefits (UIB), insurance settlements, certain types of school grants/loans/scholarships, child support, alimony, child's income, etc.

**10. Please tell us the applicant's total household assets as of the first day of this month. \$\_\_\_\_\_**

Assets can be checking and savings accounts, cash, income tax refunds, stocks and bonds, Money Market Accounts, Certificates of Deposit (CDs), time certificates, IRAs, Keogh and deferred compensation, real property (to include homes, land, and buildings) other than your primary residence, burial plans and plots, life insurance (surrender cash value), trust funds, business equity (self employed) boats and trailers, jewelry, diamonds, gold, silver and other personal property.

\*\* Refer to the SPAP brochure (DHS 8053) for different asset limits of different income levels.\*\*

**11. Please confirm that you read or had read to you the statement below by signing your name and writing the date.**

If the applicant is under 18 years of age or legally incapacitated, I certify that I am the legal parent/guardian/legal representative to submit this application on his/her/their behalf.

I certify the information I have provided on this application is true to the best of my knowledge. If I intentionally make false statements on this application, I may be prosecuted under Hawaii Revised Statutes §710-1063. I give permission to the State of Hawaii to check my statements. I have read or had read to me the list of rights and responsibilities stated below.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**I understand and agree to the following:**

1. This application is only a request to participate in the State Pharmacy Assistance Program.
2. Federal and State laws do not allow the Department of Human Services (DHS) to release any information I have provided without my written permission unless it is directly related to my participation in the State Pharmacy Assistance Program.
3. I have the right to be treated with dignity and respect without regard to my race, color, age, sex, national origin, physical or mental disability, or religious or political beliefs.
4. I am able to request access to sign or foreign language interpreters, large print, taped materials, or accessible parking, etc., at no charge, if requested ahead of time.
5. The State may conduct independent verification of the statements I made on the application.
6. I have the right to appeal decisions concerning my eligibility or provision of benefits.
7. I agree to cooperate with the DHS, its agents and contractors, and/or auditors if my case is reviewed.
8. I understand that I must report changes in my household income, family composition, or place of residence to the State Pharmacy Assistance Program within 10 days of the change.

You need to complete and sign the State Pharmacy Assistance Program application. You may fax or mail the completed and signed application form to our office. Our fax number is (808) 692-7989 and our address is:

Department of Human Services, State Pharmacy Assistance Program, PO Box 700220, Kapolei, HI 96709

DHS office hours are Monday through Friday, 7:45 a.m. to 4:30 p.m. The office is closed on State holidays and furlough days. If you have any questions about the State Pharmacy Assistance Program, Oahu residents may call 692-7999 and Neighbor Island residents may call toll-free 1-866-878-9769.

**Bilingual and Sign Interpreter Services**

<input type="checkbox"/>	Med-QUEST will provide a free bilingual or sign language interpreter. Yes, I need a _____ language interpreter.	English
<input type="checkbox"/>	<b>Med-QUEST 將會供給您一位免費的雙語翻譯員或手勢語的翻譯員。 是，我需一位 (選一個) <input type="checkbox"/>普通話 / 國語 (M) <input type="checkbox"/>廣東話 (C) 的翻譯員。</b>	Chinese
<input type="checkbox"/>	Med-QUEST epewe aora emon chon affou ese kamo, mei sinenap non poraus are ponwen poraus. U, U-mochen emon chon affou non kapasen chuuk.	Chuukese
<input type="checkbox"/>	E kōkua a hā'awi ana 'o Med-QUEST i kekahi kanaka unuhi 'ōlelo a i 'ote i kekahi kanaka "sign language." 'Ae, makemake au i kekahi kanaka unuhi 'ōlelo.	Hawaiian
<input type="checkbox"/>	Ti Med-QUEST mangled iti libre nga interprete nga makaamno iti nadumaduma a pagsasao (bilingual) wannō pagsasao babaeen iti senyal (sign). Wen, masapul ko ti interprete nga ilokano.	Ilocano
<input type="checkbox"/>	<b>Med-QUEST</b> 에서는 통역이나 수화 통역사를 무료로 제공 합니다. 네, 저는 한국 통역이 필요 합니다.	Korean
<input type="checkbox"/>	クエストが、無料で、バイリンガルあるいは手話の通訳をつけてくれます。 はい、私は日本語の通訳が必要です。	Japanese
<input type="checkbox"/>	<b>Med-QUEST</b> ຈະ ຈັດ ຈ້າງ ຜູ້ ທ່າວ ທີ່ ບໍ່ ຈ່າຍ ກ່ຽວ ກັບ ການ ທຳ ນິຕິ ຄຳ ທີ່ ຈຳ ັນ ຈຳ ັນ. Med-QUEST enaj lewōj ejelok wōnen juōn rukok ak rukok kin sign. Ael, inkuj i juōn rukok kajin majō.	Laotian
<input type="checkbox"/>	Med-QUEST pahñ kahk sawasikida sewesepehn tohn kawehwei ni sohte pweipweil. Ehi, ih anahne tohn kawehwei ohng ni lokoiahn Pohñpeian.	Pohñpeian
<input type="checkbox"/>	O le a saunia ote Med-QUEST se faamatala upu ile gagana poo le faaagaina o saini ma lima e aunoa masa totoqi. Ioe, oite manomania se faamatala upu ile gagana Samoa.	Samoa
<input type="checkbox"/>	Med-QUEST le proporcionará un intérprete sin cargo bilingüe o de lenguaje de signos. Si, necesito un intérprete de español.	Spanish
<input type="checkbox"/>	Ang Med-QUEST ay nagbibigay ng libreng interprete na makakaalam ng iba-ibang wika (bilingual) o lenggwaha sa pamamagitan ng senyas (sign). Co, kailangan ko ang interprete na Tagalog.	Tagalog
<input type="checkbox"/>	'E lava he'e Med-QUEST 'o 'omai e kau fakatonulea 'o tatau pe kihe lea moe fakal'ionga lea 'aki e nima. 'Io 'oku ou fema'u e fakatonulea.	Tongan
<input type="checkbox"/>	Med-QUEST sẽ cung cấp một thông đ ch viên song ngữ hoặc thông đ ch viên ra dấu miễn phí. Vâng, tôi sẽ n m a thông đ ch viên song ngữ hoặc c thông đ ch viên ra dấu miễn phí.	Vietnamese