

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

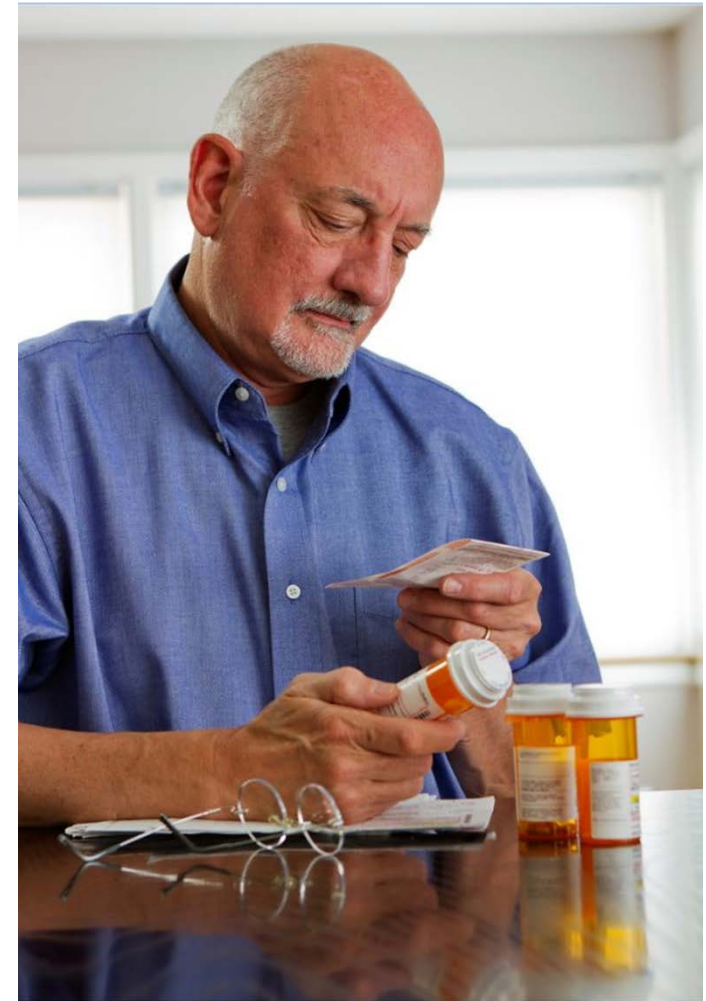
Return original completed application and additional documents to:

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**

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



**R<sub>x</sub>**



**DXC** **DXC.technology**

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**

<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Social Security Number</b>		<b>Date of Birth</b>
			- -		/ /
<b>Street</b>		<b>Apt.</b>	<b>City</b>	<b>Zip</b>	<b>County</b>
				19	N K S
<b>Race (optional)</b>		<b>Sex</b>	<b>Marital Status</b>		<b>US Citizen</b>
<input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Never Married		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Do you receive:**

Social Security Disability Benefits? <input type="checkbox"/> No <input type="checkbox"/> Yes   List Amount:
Other income: <input type="checkbox"/> No <input type="checkbox"/> Yes   How often:   List Amount:
Do you have Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you receive Extra help from Social Security? <input type="checkbox"/> No <input type="checkbox"/> Yes
Other pharmacy coverage or Medicare Part D coverage? <input type="checkbox"/> No <input type="checkbox"/> 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 each 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  
 If representative, please print name, relationship and phone number.

\_\_\_\_\_  
 Date

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_