

DELAWARE
Prescription Assistance
PROGRAM
A prescription for better health

client name

client address1

client address2 client apt

client city, state zip

MID: client MID

SSN: soc-sec

Phone: Client phone

AID Cat: Aid Ctg

Dear client full name,

It is time to reenroll in the Delaware Prescription Assistance Program (DPAP). **To continue your enrollment effective January 1, 2006**, please check that the **above information** is correctly recorded. Make any necessary changes by drawing a line through the incorrect information and adding the correct information next to it.

Your benefit expires on December 31, 2005. To re-enroll and make sure there is no interruption to your benefits, please:

- 1. Send proof of income. If married, supply both your and your spouse's incomes, even if your spouse is not enrolled in the program.**
- 2. Marital status (please circle one): *Married Single Divorced Widowed Separated***
- 3. Do you have other pharmacy insurance? *Yes No***
If yes, please include name, phone number, and ID # of your pharmacy insurance.

- 4. Are you a U.S. Citizen? *Yes No***
If you are not a U.S. Citizen, please send proof of immigration status.
- 5. Are you eligible for Medicare? *Yes No***
If yes, you must enroll with a Medicare Prescription Drug Plan and show proof. If you may be eligible for the extra help, you must apply with Social Security and show proof of approval or denial.
- 6. Please sign and date this letter and attach any necessary documentation. Please return all information by November 30, 2005.**

VERIFY, READ, AND SIGN 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 complete and true 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.

Signature of Applicant or Representative

Date

Relationship/Phone Number of Representative

LCN: 999999999