

## **IMPORTANT INFORMATION TO HELP YOU COMPLETE THE SPBP RECERTIFICATION FORM**

### **SECTION A:**

- Please review the pre-printed information in Section A. Make sure that your name, address, city, state, zip code, birth date, and telephone number are correct.
- Strike out any information that is incorrect and legibly print the correct information in a blank area in Section A.
- If you are reporting a change to your name, address, or date of birth, you will need to provide proof of the change. Some examples of proof are a copy of one of the following: a recent phone/utility bill, your social security award letter, your current driver's license, your birth certificate to verify date of birth, etc.
- If you are reporting a correction to your Social Security Number, please send a photocopy of your Social Security Card.
- Select your language preference by putting a check mark (✓) after English, Spanish or write it in the space provided after "Other".

### **SECTION B:**

- List all members of your family who live with you, along with the birth date, sex, social security number and relationship to you. Family includes your spouse and children under 21 years of age who live with you.
- Attach an extra sheet of paper if you run out of space.

### **SECTION C:**

- Please provide your most current income information and the most current income information for each member of your family that is listed in SECTION B.
- Enter your total annual gross income (before any taxes or deductions).
- List each source of your income and the gross amount paid in the section that best reflects how often you are paid: weekly, bi-weekly or monthly. Examples of sources of income include salary, wages, unemployment benefits, Veterans' benefits, Social Security benefits, pensions, retirement benefits, Workers' Compensation, alimony, child support, dividends, interest, royalties, self-employment, etc.
- Enter the total annual gross income (before any taxes or deductions) for each member of your family listed in SECTION B.
- List each source of each family member's income and the gross amount paid in the section that best reflects how often the member is paid: weekly, bi-weekly or monthly. Examples of sources of income include salary, wages, unemployment benefits, Veterans' benefits, Social Security benefits, pensions, retirement benefits, Workers' Compensation, alimony, child support, dividends, interest, royalties, self-employment, etc.
- Proof of all income must be provided.
- Examples of proof of income include photo copies of pay stubs, a letter from the employer indicating gross pay for the last 30 calendar days, your most recent income tax form, unemployment checks, social security checks, pension checks, a benefit award letter, etc.
- If you are self-employed, include signed copies of previous year's federal tax filings including Schedule C and/or third party copies of business records for the past three (3) months indicating gross and net revenue.
- If you have zero income, include a letter that is dated and signed detailing how you are meeting your daily needs. This letter may be written by you or a caregiver, family member or caseworker. If you applied for Medical Assistance benefits within the past year, list the benefits you applied for and the status of each application. If your application was approved, please include a copy of the approval or award letter. If your application was denied, please include a copy of the denial letter.

**SECTION D:**

- Place a checkmark (✓) in the box to indicate all health programs or Private Insurance in which you are enrolled. You must provide a copy of the front and back of all your Membership ID Cards. Do not send copies of your SPBP membership card because we already have that information on file.
- If you have Other Private Insurance, place a checkmark in that box and write the name of the Other Private Insurance in the space provided.
- Proof of all health insurance information must be provided. Examples of proof are photocopies of your health and prescription identification cards that show your name and insurance ID number.

**SECTION E:**

- **PLEASE SIGN AND DATE YOUR APPLICATION.**

Check the boxes below to be sure you have completed and enclosed copies of:

Proof of Income for you and family members  Your Signature and Date

Proof of Health/Prescription Coverage  Proof of new name or address, corrected date of birth or corrected Social Security Number

**MISSING OR INCOMPLETE INFORMATION MAY DELAY YOUR ACCESS TO BENEFITS.**

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- **YOU ARE REQUIRED TO RECERTIFY YOUR SPBP ELIGIBILITY ANNUALLY.**
  - **YOU MUST COMPLETE AND RETURN THE SPBP RECERTIFICATION FORM WITHIN 30 DAYS OR YOUR ELIGIBILITY FOR SPBP BENEFITS WILL BE CLOSED, EVEN IF YOU RECENTLY RETURNED YOUR RECERTIFICATION FORM FOR LAST YEAR.**
  - **IF YOU NEED HELP, PLEASE ASK A FRIEND OR FAMILY MEMBER TO HELP YOU FILL OUT THE FORM AND MAKE REQUIRED PHOTOCOPIES OR CALL THE SPBP STAFF AT 1-800-225-7223.**
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សំបុត្រនេះមានព័ត៌មានសំខាន់អំពីច្បាប់ថ្មីដើម្បីយកថ្នាំរបស់លោកអ្នក។ សូម  
ទូរស័ព្ទ 1-866-872-8969 បើលោកអ្នកត្រូវការសំបុត្រនេះជាភាសាផ្សេងទៀត  
ឬត្រូវការអ្នកបកប្រែ។ ការបកប្រែភាសាផ្តល់ឲ្យដោយឥតគិតថ្លៃ។

此通知的重要信息是有关您获得药品的新规定。如果您需要该通知译成其他语言或  
需要有人替你翻译，请致电1-866-872-8969。此服务是免费的。

Данное уведомление содержит важную информацию о новых правилах  
получения лекарств. Звоните 1-866-872-8969, если оно вам нужно на другом  
языке или нужна помощь переводчика. И то и другое предоставляется  
бесплатно.

Este aviso contiene información importante acerca de las reglas nuevas para  
obtener su medicina. Llame al 1-866-872-8969 si necesita esto en otro idioma o  
si necesita un intérprete. El servicio es gratuito.

Thông báo này gồm những điều lệ mới quan trọng khi quý vị đi lấy thuốc. Cần bản tin  
này bằng thứ tiếng khác cần một thông dịch viên, xin quý vị gọi số 1-866-872-8969.  
Dịch vụ này được miễn phí.