

**COPAYMENT ASSISTANCE – Skip page if you do not have:  
Medicare part D (State Pharmaceutical Assistance Program)  
Or Private Insurance (Texas Insurance Assistance Program)**

**Applicants with MEDICARE or PRIVATE INSURANCE should fill out this form in addition to the main THMP form.** Applicants with insurance or Medicare part D are eligible for assistance. The SPAP provides help with co-pays, coinsurance and gap coverage associated with a Medicare Part D prescription drug plan. The TIAP provides help with co-pays, coinsurance and premiums associated with COBRA plans and private insurance.

First and Last Name	Social Security Number	Date of Birth
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**DO YOU HAVE MEDICARE? FILL THIS SECTION**

Your Medicare Number	Effective Date of Medicare Part A (listed on your Red White & Blue Medicare Card)
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Are you enrolled in a Medicare Prescription Drug Plan (Part D)?  No  Yes (if yes, please provide plan information below)

Plan Name:	Effective Date:
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Have you applied for the Low Income Subsidy or Extra Help through the Social Security Administration?  No  Yes (please indicate application status below)

Low Income Subsidy/Extra Help Application Status

Approved, 100% Assistance  Denied Assistance (attach a copy of pre-decisional or denial letter)

Approved, partial assistance (attach copy of approval letter)  Awaiting determination, application date:

**DO YOU HAVE INSURANCE? FILL THIS SECTION INSTEAD**

Are you enrolled in a private insurance plan?  No  Yes (if yes, please provide plan information below)

Plan Name:	Effective Date:	Member ID
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Do you have an Affordable Care Act (ACA) Marketplace Plan?  Yes  No Is it: Gold  Silver  Bronze   
(If yes, provide information on your approved subsidy or tax credit)

**PROVIDE COPY OF FRONT & BACK OF INSURANCE CARD**

Is this an Individual, Non-ACA, Off Marketplace Plan?  Yes  No  
Is this plan offered through an employer?  Yes  No

If you have COBRA or may be eligible for COBRA, please submit copies of your COBRA paperwork:

Have you already submitted your COBRA paperwork?  No  Yes date submitted: \_\_\_\_\_ COBRA Election/Enrollment Due Date: \_\_\_\_\_  
COBRA Administrator's Phone Number: \_\_\_\_\_ COBRA Initial Payment Due Date: \_\_\_\_\_  
COBRA Account #: \_\_\_\_\_

**COPAYMENT ASSISTANCE AGREEMENT**

- 1) I understand that it is my responsibility to:
  - a) enroll in an insurance plan or enroll in a Medicare Prescription Drug Plan and apply for the Low Income Subsidy,
  - b) maintain my enrollment in an insurance plan or 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 THMP SPAP immediately if any of the following happen:
  - a) my household income changes, b) my address changes or I move out of the State of Texas, c) my marital status changes, or d) my Medicare benefits are terminated, I lose my insurance coverage or my eligibility for Medicaid or Medicare changes
- 3) I understand that the THMP reserves the right to limit enrollment based upon availability of funds.
- 4) I understand that the THMP is required to recertify my eligibility status per program rules in order to continue receiving services.
- 5) I understand that information may be shared with THMP staff and my insurance plan. I hereby give consent to the THMP to obtain or release my demographic, medical and /or insurance coverage information with other entities as necessary.
- 6) I agree to participate in a periodic follow up by the THMP Insurance Assistance Program staff to determine the effectiveness of the program.
- 7) 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 THMP, including the Texas THMP SPAP, and (3) attests that I do reside in the State of Texas.

Signature of Applicant (please print and sign)	Date
Signature of Parent (if applicant is under 18) (please print and sign)	Date