

CARDHOLDER ENROLLMENT APPLICATION

This Application is for initial enrollment in the Chronic Renal Disease Program (CRDP). **This application will not be accepted for re-enrollment.**

You are eligible to participate in the Chronic Renal Disease Program if:

- YOU HAVE END-STAGE RENAL DISEASE AND ARE CURRENTLY RECEIVING DIALYSIS OR HAVE HAD A KIDNEY TRANSPLANT; AND
- YOU HAVE LIVED IN PENNSYLVANIA FOR AT LEAST 90 DAYS PRIOR TO THE DATE OF YOUR APPLICATION OR YOU CAN SHOW AN INTENT TO MAINTAIN A PERMANENT HOME IN PENNSYLVANIA FOR THE INDEFINITE FUTURE; AND
- YOU ARE A U.S. CITIZEN OR LEGAL ALIEN; AND
- YOUR INCOME IS WITHIN GUIDELINES SPECIFIED BY THE PENNSYLVANIA DEPARTMENT OF HEALTH.

CRDP ELIGIBILITY REQUIREMENTS

CITIZENSHIP ***(proof required)***

To be eligible for the CRDP, you must be a U.S. Citizen or Legal Alien (admitted under the Immigration Reform and Control Act of 1986 (IRCA) or qualify for refugee/asylum status). Submit a photocopy of one of the following documents for proof of citizenship (Do not send originals. 8½" x 11" photocopies are preferred.):

- Birth certificate
- Naturalization papers
- Immigration and Naturalization Service documents
- PA Department of Public Welfare Medical Assistance identification card
- U.S. passport
- School record
- Military service documents showing date of birth
- Notarized statement
- Voter registration card
- Religious record showing date of birth (example: Tribal record/Baptismal certificate issued on Indian reservation)
- Any document from the Social Security Administration showing name, Social Security number, etc. (except a Social Security card)

RESIDENCY ***(proof required)***

To be eligible for the CRDP, you must have lived in Pennsylvania at least 90 days prior to the date of this application or must be able to show an intent to maintain a permanent home in Pennsylvania for the indefinite future.

Submit a photocopy of one of the following documents for proof of residency. (Do not send originals. 8½" x 11" photocopies are preferred.) Documents cannot be older than two years:

- Federal, state or local income tax return with a pre-printed name and address label
- Driver's license or vehicle owner's card
- Utility receipts
- Pre-printed rent receipts
- Long-term care residents may submit a letter on the facility's stationery, signed by the director or administrator, stating admission date
- Unemployment Compensation card
- Dated PA Department of Public Welfare correspondence
- Dated Social Security correspondence

ANNUAL INCOME ***(proof required)***

DOCUMENTATION FOR PROOF OF INCOME

If you completed a Federal 1040 Tax Form, you must attach a photocopy of your previous year's tax form to your application. The 1040 Tax Form is the document you must use to support the income listed on your application.

If you receive Social Security benefits, you must also submit a photocopy of your previous year's SSA-1099.

If you did not complete a Federal Tax Form, you must read the following and attach the appropriate documents required to support the income.

CRDP ELIGIBILITY REQUIREMENTS

Photocopies of the following documents are acceptable as proof of income:

- **LINE 1: TOTAL PREVIOUS YEAR'S GROSS SOCIAL SECURITY. INCLUDE MEDICARE PREMIUMS AND SUPPLEMENTAL SECURITY INCOME (SSI).**

A photocopy of SSA Form 1099, "Social Security Benefit Statement," or a computer printout of your Social Security benefits from SSA.

- **LINE 2: TOTAL PREVIOUS YEAR'S GROSS RAILROAD RETIREMENT BENEFITS (RRB-1099 AND RRB-1099R FORM).**

A photocopy of the letter from the Fund Administrator verifying previous year's pension and annuity income or Form RRB-1099 AND RRB-1099R, "United States Railroad Retirement Board Statement." (Both forms must be submitted.)

- **LINE 3A: TOTAL PREVIOUS YEAR'S SERS (STATE EMPLOYEE'S RETIREMENT). This applies to Retired State Employees Only.**
- **LINE 3B: TOTAL PREVIOUS YEAR'S PSERS PENSION (PUBLIC SCHOOL EMPLOYEES' RETIREMENT). This applies to Retired Public School Employees Only.**

A photocopy of the letter from the Fund Administrator verifying previous year's pension or 1099 form.

- **LINE 4: TOTAL PREVIOUS YEAR'S GROSS PENSIONS (not listed in 3A and 3B), and TAXABLE AMOUNT OF ALL ANNUITIES AND INDIVIDUAL RETIREMENT ACCOUNTS (IRAs).**

A photocopy of Form 1099 for all pensions, annuities and Individual Retirement Accounts (IRAs) must be included.

- **LINE 5: TOTAL PREVIOUS YEAR'S INTEREST, DIVIDENDS, CAPITAL GAINS AND PRIZES (DO NOT SUBTRACT LOSSES FROM TOTAL INCOME).**

Proceeds from the sale of your home, when used to purchase another residence for you or your spouse (must be deeded in your name or your spouse's name) or to provide long-term care for you or your spouse, is not considered income, but must be documented. (Interest earned on bank accounts established with the capital gains must be reported.)

Bank statements or similar financial statements should contain the end-of-year interest totals, name of bank and applicant name.

- **LINE 6: WAGES, SALARY, BONUSES, COMMISSIONS, SELF-EMPLOYMENT, PARTNERSHIPS, NET RENTAL, NET BUSINESS, CASH PUBLIC ASSISTANCE, UNEMPLOYMENT, WORKERS' COMP., ALIMONY, SUPPORT, GAMBLING, GIFTS AND INHERITANCE OVER \$300, AND DEATH BENEFITS OVER \$5,000.**

Photocopy of W-2 form; 1099 form; the letter from the source of income identifying the award; notarized letter providing specific information such as amount and source of income, address or phone number of source of income and applicant's name; alimony check or payment record from court.

Rent rebate forms cannot be used to document income.

CRDP ELIGIBILITY REQUIREMENTS

EXCLUDED INCOMES

The following types of income should **not** be included in your annual income figures:

- Black or white lung benefits
- The first \$5,000 in death benefit payments (Example: If you received a \$6,000 death benefit, only \$1,000 should be reported as income.)
- Non-cash relief, including food stamps and the 504 Loan and Grant Program from FHA
- Property tax/rent rebate payments
- The amount of damages received, whether by civil suit or settlement agreement, due to personal injuries
- Low Income Home Energy Assistance Program (LIHEAP) payments
- Gifts totaling \$300 or less
- Refund from Income Tax

ACCEPTABLE DOCUMENTS TO PROVE SOCIAL SECURITY NUMBER

- Social Security card
- Social Security Administration 1099 or SSA-100 Statement
- W-2 Wage and Tax Statement
- 1099 or 1099-R Pension Statement
- Current pay stub identifying applicant's name, address and Social Security number.

SIGNATURE INSTRUCTIONS

Sign and date the application. If a signature is made with a mark (X), a witness must sign in the space provided. Power of Attorney or guardianship documentation must accompany the application when signed by the Attorney-In-Fact or Court-Appointed Guardian.

NON-CREDITABLE COVERAGE

Since the CRDP offers a limited formulary, the prescription coverage received from CRDP is not equivalent to the prescription benefits offered by Medicare Part D, which means CRDP is considered “non-creditable.” This means it may be in your best interest to be enrolled in CRDP and a Medicare Part D plan together.

When you become eligible for Medicare, if you do not have any prescription coverage that is considered creditable, you should enroll in a Medicare Part D plan. Otherwise, you may pay a higher premium to join a Medicare drug plan. If you go 63 days or longer without prescription drug benefits that are at least as good as the coverage offered through the Medicare benefit, you will have to pay a 1% penalty on the monthly Part D premium for every month you go without coverage.

After you are enrolled in CRDP, the program can assist you in enrolling in a Part D plan when you become Medicare eligible or during the Part D annual enrollment period.

IMPORTANT FACTS

Carefully review your income statement and make certain that you have reported all income you received during the previous year. Other sources of tax information may be used by the Department of Health or its authorized representative to verify your income statement.

- To expedite the processing of your application, please:
 - **Type or print with black ink;**
 - Include the documentation as mentioned in the “CRDP Eligibility Requirements” section of this booklet; and
 - Submit all photocopies on **8 1/2" x 11"** white paper. Be sure photocopies are one-sided and clear so they can be easily read.
- Eligible applicants must pay a copayment for each prescription.
- You may be required to meet a Patient Share of Cost (PSC) prior to receiving medical benefits. The PSC is the amount of money that you must contribute to the cost of your medical care. The amount is determined by your annual income.
- A CRDP card **cannot be forwarded to another address** in or outside Pennsylvania.
- CRDP does not provide for vacation or emergency supplies, medications or dialysis services which are rendered outside Pennsylvania. If you leave Pennsylvania, you are responsible for notifying CRDP of your departure and return dates.
- Only contracted or approved providers that are currently licensed by the Commonwealth and which have their principal place of business in this Commonwealth are eligible to participate in this program.
- Your pharmacist may dispense a 30-day supply or 100 capsules or tablets per prescription, whichever is less. Seventy-five percent (75%) of the medication must be used before the prescription can be refilled.
- CRDP reimburses up to five (5) refills on a prescription or a six (6) month supply, whichever occurs first.
- If at any time your income is found to exceed CRDP limits, your benefits will be canceled and you may be responsible for any medical care or prescription costs improperly paid on your behalf. In most cases, repayments are based on the coverage period.
- Any other medical or prescription coverage you have must be used as the primary payor. CRDP providers may not bill CRDP before billing your other third party carrier.
- If you are enrolled in a Part D plan and CRDP at the same time, the CRDP may pay your Part D monthly premium for you, cover any deductibles, and cover any copays in excess of your CRDP copay on CRDP formulary medications as long as the Part D plan has an agreement with us. For further information regarding the Part D plans, please call our toll-free cardholder services number at 1-800-225-7223.

INSTRUCTIONS FOR COMPLETING THE CRDP APPLICATION

IMPORTANT: Must type or print with black ink.

A Print your **name, Social Security number (you must enclose a photocopy of your Social Security card), home address, birth date, and telephone number.** When entering your birth date, please use the number for the month, day and year. (Example: If your birth date is February 23, 1941, enter 02/23/1941.)

B Please provide your **spouse's (husband/wife) name and your spouse's Social Security number.** **CITIZENSHIP STATUS:** The patient must be a United States citizen or legal alien. You must send a photocopy of the following documents for proof of citizenship: birth certificate, naturalization papers or INS documents.

C **RACE:** (Optional) Circle the number that best describes your race.
ETHNICITY: (Optional) Circle the number that best describes your ethnic origin.

D **SEX:** Circle #1 for Male or #2 for Female.
MARITAL STATUS: Circle the number which best describes your marital status. When circling #3 or #4, you must include the year.

E **HEALTH COVERAGE:** Complete the attached Health Coverage Information Sheet. **You must enclose photocopies of all health coverage identification cards.** Be sure to include all information requested.

F **EVIDENCE OF INCOME:** **8 1/2" x 11" photocopies of documents are preferred.**

All applicants must complete lines 1 through 7. Please attach photocopies of your signed IRS 1040 income tax forms, including tax schedules, which will verify the income reported in this section. Attach a photocopy of all SSA-1099 forms if applicable.

Read and answer the four questions regarding your Federal tax filing for the prior year. If you checked "yes" to any of the questions, report income of all persons claimed on the Federal 1040 income tax form in the income section, lines 1 through 6.

If you do not file an IRS 1040 income tax form, you must submit photocopies of documents to support the income you have listed on this document. If you have indicated no income on line 7, please attach an explanation of how your daily living expenses are being paid.

Read the "**CERTIFICATION AND AUTHORIZATION**" statements on the back of the application.

G **SIGN AND DATE THE APPLICATION:** If the applicant's signature is made with a mark (X), a witness or preparer must sign and provide their phone number in the space provided.

H **POWER OF ATTORNEY OR GUARDIAN:** Power of Attorney or guardianship documentation must accompany the application when signed by the Attorney-In-Fact or Court-Appointed Guardian.

PHYSICIAN'S STATEMENT: The physician, advanced practice registered nurse, certified registered nurse practitioner or physician's assistant responsible for your renal treatment must complete and sign the statement.

THIS PHYSICIAN'S STATEMENT MUST BE RETURNED WITH YOUR APPLICATION

Patient's Name: _____

Patient's Social Security Number - -

CONFIDENTIAL

Application for Services

THIS SECTION MUST BE COMPLETED, SIGNED AND DATED BY THE PATIENT'S ATTENDING PHYSICIAN.

I CERTIFY THAT THIS PATIENT IS IN END-STAGE RENAL DISEASE, ICD-9-CM CODE 585, OR HAD A KIDNEY TRANSPLANT, ICD-9-CM CODE V42.

INDICATE BELOW THE APPROPRIATE ICD-9-CM CODE AND DESCRIPTION FOR THE PRIMARY CAUSE OF END-STAGE RENAL DISEASE:

ICD-9-CM CODE

.

PLEASE LIST ANY APPROPRIATE SECONDARY ICD-9-CM CODES AND DESCRIPTIONS:

ICD-9-CM CODE

.

CHECK THE TYPE OF SERVICE RENDERED TO THE PATIENT:
(Check One Only - if transplant recipient and not receiving dialysis do not complete dialysis information)

DIALYSIS TRANSPLANT

DATE OF TRANSPLANT: _____
MM DD YYYY

IF ON DIALYSIS, CHECK PLACE OF TREATMENT: DIALYSIS CENTER

HOME DIALYSIS METHOD I METHOD II

IF ON DIALYSIS, CHECK TYPE OF DIALYSIS: HEMODIALYSIS CAPD CCPD OTHER _____

ENTER DATE OF FIRST DIALYSIS TREATMENT: _____
MM DD YYYY

DATE DIALYSIS STARTED _____
IN CURRENT CENTER: MM DD YYYY
(IF DIFFERENT THAN DATE OF FIRST DIALYSIS)

NUMBER OF TREATMENTS PER WEEK: _____

I certify that the narrative description(s) of the patient's diagnosis(es) are complete, as written, and accurate to the best of my knowledge, and I have obtained appropriate written consent for the disclosure of this medical information including written consent for the disclosure of any HIV-related information as set forth in Section 7607 of the Confidentiality of HIV-Related Information Act, 35 P.S. Section 7601 et. seq.

Physician's Signature (APRN, CRNP, or PA signature also accepted)

Date MM DD YYYY

Physician's Name (Last, First) _____

Physician's Tax ID Number _____ (Check one) SSN _____ FID _____

Physician's NPI Number

Facility or Medical Practice Medicare Provider Number -

Facility or Medical Practice NPI Number

Dialysis/Transplant/Treating Physician Facility Name _____

Address _____

City _____ State _____ Zip Code + Four _____

Phone # () _____

Social Worker/Transplant Coordinator/Treating Physician Office Email: _____

**CHRONIC RENAL DISEASE PROGRAM
LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE**

Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-CM code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary.

ICD-9 NARRATIVE

DIABETES

- 25040 Diabetes with renal manifestations Type 2
- 25041 Diabetes with renal manifestations Type 1

GLOMERULONEPHRITIS

- 5829 Glomerulonephritis (GN)
(histologically not examined)
- 5821 Focal glomerulosclerosis, focal sclerosing GN
- 5831 Membranous nephropathy
- 58321 Membranoproliferative GN type 1, diffuse MPGN
- 58322 Dense deposit disease, MPGN type 2
- 58381 IgA nephropathy, Berger's disease
(proven by immunofluorescence)
- 58382 IgM nephropathy (proven by immunofluorescence)
- 5834 With lesion of rapidly progressive GN
- 5800 Post infectious GN, SBE
- 5820 Other proliferative GN

SECONDARY GN/VASCULITIS

- 7100 Lupus erythematosus, (SLE nephritis)
- 2870 Henoch-Schonlein syndrome
- 7101 Scleroderma
- 28311 Hemolytic uremic syndrome
- 4460 Polyarteritis
- 4464 Wegener's granulomatosis
- 58392 Nephropathy due to heroin abuse and related drugs
- 44620 Other Vasculitis and its derivatives
- 44621 Goodpasture's syndrome
- 58391 Secondary GN, other

INTERSTITIAL NEPHRITIS/PYELONEPHRITIS

- 9659 Analgesic abuse
- 5830 Radiation nephritis
- 9849 Lead nephropathy
- 5909 Nephropathy caused by other agents
- 27410 Gouty nephropathy
- 5920 Nephrolithiasis
- 5996 Acquired obstructive uropathy
- 5900 Chronic pyelonephritis, reflux nephropathy
- 58389 Chronic interstitial nephritis
- 58089 Acute interstitial nephritis
- 5929 Urolithiasis
- 27549 Other disorders of calcium metabolism

HYPERTENSION/LARGE VESSEL DISEASE

- 40391 Unspecified with renal failure
- 4401 Renal artery stenosis
- 59381 Renal artery occlusion
- 59383 Cholesterol emboli, renal emboli

ICD-9 NARRATIVE

CYSTIC/HEREDITARY/CONGENITAL DISEASES

- 75313 Polycystic kidneys, adult type (dominant)
- 75314 Polycystic, infantile (recessive)
- 75316 Medullary cystic disease, including nephronophthisis
- 7595 Tuberosus sclerosis
- 7598 Hereditary nephritis, Alport's syndrome
- 2700 Cystinosis
- 2718 Primary oxalosis
- 2727 Fabry's disease
- 7533 Congenital nephrotic syndrome
- 5839 Drash syndrome, mesangial sclerosis
- 75321 Congenital obstruction of ureteropelvic junction
- 75322 Congenital obstruction of ureterovesical junction
- 75329 Other Congenital obstructive uropathy
- 7530 Renal hypoplasia, dysplasia, oligonephronia
- 75671 Prune belly syndrome
- 75989 Other (congenital malformation syndromes)

NEOPLASMS/TUMORS

- 1890 Renal tumor (malignant)
- 1899 Urinary tract tumor (malignant)
- 2230 Renal tumor (benign)
- 2239 Urinary tract tumor (benign)
- 23951 Renal tumor (unspecified)
- 23952 Urinary tract tumor (unspecified)
- 20280 Lymphoma of kidneys
- 20300 Multiple myeloma
- 20308 Other immuno proliferative neoplasms
(including light chain nephropathy)
- 2773 Amyloidosis
- 99680 Complications of transplanted organ unspecified
- 99681 Complications of transplanted kidney
- 99682 Complications of transplanted liver
- 99683 Complications of transplanted heart
- 99684 Complications of transplanted lung
- 99685 Complications of transplanted bone marrow
- 99686 Complications of transplanted pancreas
- 99687 Complications of transplanted intestine
- 99689 Complications of other specified transplanted organ

MISCELLANEOUS CONDITIONS

- 28260 Sickle cell disease/anemia
- 28269 Sickle cell trait and other sickle cell (HbS/Hb other)
- 64620 Post partum renal failure
- 042 AIDS nephropathy
- 8660 Traumatic or surgical loss of kidney(s)
- 5724 Hepatorenal syndrome
- 5836 Tubular necrosis (no recovery)
- 59389 Other renal disorders
- 7999 Etiology uncertain

CHECK-OFF LIST

HAVE YOU:

- Filled out the form completely, using black ink?
- Read the Certification and Authorization Statements?
- Signed and dated the application?
- Included a photocopy of your previous year's signed IRS 1040 income tax form, plus tax schedules? If you did not file an IRS 1040 for the previous tax year, have you attached the appropriate documents to verify the income figures listed on the application?
- Included a photocopy of your previous year's SSA-1099 form(s), if applicable?
- Included proof of Power of Attorney or Court-Appointed Guardianship, if needed?
- Included the Physician's Statement?
- Included the Health Coverage Information Sheet?
- Included photocopies of all health coverage identification cards (inclusive of Medical Assistance and Medicare coverage cards)?
- Included a photocopy of your Social Security card or proof that you have applied for a Social Security number?
- Included a photocopy of proof of citizenship?
- Included a photocopy of proof of residency?

Use the enclosed envelope and mail your application and required documents to:

**Pennsylvania Department of Health
Eligibility Unit
P.O. Box 8811
Harrisburg, PA 17105-8811**

**NEED ASSISTANCE WITH THIS APPLICATION
OR HAVE QUESTIONS REGARDING ELIGIBILITY?**

**CALL
TOLL-FREE
1-800-225-7223**

**HEARING IMPAIRED NUMBER
1-800-222-9004
(Only calls from hearing
impaired individuals will
be accepted at this number)**

**FAX NUMBER
(717) 651-3608**

COLLECT CALLS WILL NOT BE ACCEPTED

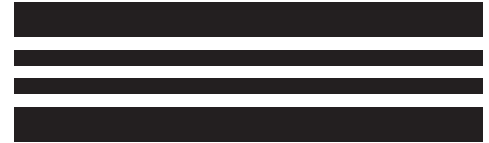
Commonwealth of Pennsylvania
Department of Health



CHRONIC RENAL DISEASE PROGRAM

ELIGIBILITY UNIT
P.O. BOX 8811
HARRISBURG, PA 17105-8811

CARDHOLDER APPLICATION



MUST TYPE OR PRINT WITH BLACK INK

A	LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY #
	HOME ADDRESS (PROOF REQUIRED)			BIRTH DATE (MM) (DD) (YYYY)
CITY			STATE	ZIP
B	SPOUSE'S NAME			CITIZENSHIP STATUS (CHECK ONE)
	SPOUSE'S SOCIAL SECURITY #			<input type="checkbox"/> US CITIZEN <input type="checkbox"/> LEGAL ALIEN <input type="checkbox"/> OTHER (EXPLAIN)
C	RACE (CIRCLE ONE) (OPTIONAL) 1 AMERICAN INDIAN/ALASKAN NATIVE 2 ASIAN/PACIFIC ISLANDER 3 BLACK/AFRICAN AMERICAN 4 WHITE 5 MULTIRACIAL/OTHER 6 UNKNOWN	ETHNICITY (OPTIONAL) (CIRCLE ONE) 1 HISPANIC ORIGIN 2 NOT OF HISPANIC ORIGIN	D SEX (CIRCLE ONE) 1 MALE 2 FEMALE	MARITAL STATUS (CIRCLE ONE) 1 SINGLE/WIDOWED 2 MARRIED 3 DIVORCED SINCE YEAR _____ 4 MARRIED-LIVING SEPARATELY SINCE YEAR _____ (YEAR REQUIRED)
E	HEALTH COVERAGE: Complete "Health Coverage Information Sheet" and attach photocopies of all insurance cards to the application.			
F	EVIDENCE OF INCOME: (PROOF REQUIRED) (MARRIED PERSONS LIVING TOGETHER MUST REPORT COMBINED INCOME EVEN IF FILING SEPARATE FEDERAL 1040 INCOME TAX FORMS)			
Indicate number of individuals residing in household: _____ Did you file a Federal 1040 income tax form for the prior year? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you claim any dependents on your 1040 for the prior year? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," how many dependents did you claim? _____ Did anyone else claim you as a dependent on a 1040 for the prior year? <input type="checkbox"/> Yes <input type="checkbox"/> No				INCOME
1	Total Previous Year's Gross Social Security - Include Medicare Premiums and Supplemental Security Income (SSI)			
2	Total Previous Year's Gross Railroad Retirement Benefits (RRB-1099 and RRB-1099R Form)			
3A	Total Previous Year's SERS Pension (State Employees' Retirement) This applies to Retired State Employees Only			
3B	Total Previous Year's PSERS Pension (Public School Employees' Retirement) This applies to Retired Public School Employees Only			
4	Total Previous Year's Gross Pensions (not listed in 3A & 3B above), and Taxable Amount of All Annuities and IRAs			
5	Total Previous Year's Interest, Dividends, Capital Gains and Prizes			
6	Wages, Salary, Bonuses, Commissions, Self-employment, Partnerships, Net Rental, Net Business, Cash Public Assistance, Unemployment, Workers' Comp., Alimony, Support, Gambling, Gifts & Inheritance over \$300, & Death Benefits over \$5,000			
7	TOTAL ANNUAL INCOME (Add lines 1 through 6)			
G	By signing, I acknowledge that I have read the Certification and Authorization Statements on the back of this application and agree to the terms stated, and that I have lived in Pennsylvania for at least 90 days or intend to maintain a permanent home in Pennsylvania, and that all information supplied herein is true, correct and complete.			
H	APPLICANT SIGNATURE (MUST BE SIGNED OR MARKED WITH AN X)		DATE / / (MM) (DD) (YYYY)	WITNESS/PREPARER'S SIGNATURE AND PHONE #
	POWER OF ATTORNEY OR COURT-APPOINTED GUARDIAN MAY SIGN FOR APPLICANT (PROOF REQUIRED)		<input type="checkbox"/> Physician's Statement Attached	

CERTIFICATION AND AUTHORIZATION STATEMENTS

I understand that my signature on the Chronic Renal Disease Program (CRDP) application indicates my agreement to the following provisions:

- A. I authorize the Internal Revenue Service, the Social Security Administration, the U.S. Railroad Retirement Board, the PA Dept. of Revenue, the PA Dept. of Transportation, the Public School Employees' Retirement System, the State Employees' Retirement System, any other federal or state agency and any other financial or other institution or entity with information on my income or resources to release information to the Dept. of Health that will verify my eligibility for the CRDP or for the low income subsidy of the federal Medicare prescription drug benefit. All information released to the Department of Health shall remain confidential in accordance with 72 P.S. § 3761-517(b).
- B. I authorize the Department of Health or its authorized representative to visit my residence with reasonable prior notice to me, for the purpose of determining the validity of information provided on the application or any claims made under CRDP.
- C. I understand that the Department of Health or its authorized representative, within its discretion, may disclose any and all medical information in my CRDP file with the exception of any HIV-related information, to business partners, contractors, grantees, and other public health programs for the legitimate business purposes of the CRDP. I agree to authorize such disclosure of information, if a further written authorization is required, by executing an appropriate authorization form.
- D. I hereby assign to the Commonwealth of Pennsylvania, in the event of duplicate or overpayment, any right to benefits to which I may be entitled under any other plan of government assistance or insurance from any third party payor. I hereby designate the Commonwealth of Pennsylvania's CRDP, acting through its contractors and agents, as my agent and authorized representative for the limited purpose of applying for such government assistance or insurance. I understand that I may decline the choice of third party payor that may be made by CRDP on my behalf by indicating my preference of appropriate third party payor to CRDP in writing.
- E. I hereby waive the confidentiality of any health care information found in any Medicare HMO, third party payor's file or any other health care source, except for HIV-related information; I authorize disclosure of this information to the CRDP, its contractors and agents. If the holders of this information require further signed authorizations in order to disclose information about me, I agree that I will cooperate with the Department and promptly execute the appropriate authorizations.
- F. I agree that I will not receive payment, or authorize the receipt of payment on my behalf, from the Department of Health for any amount which has been paid by any other plan of government assistance or insurance or any other third party payor on my behalf.
- G. I understand that if it is determined that CRDP benefits have been paid improperly, I shall be required to repay such benefits. I authorize such collections from myself, my estate, my agents, and my personal representatives.
- H. I understand that any person who submits a false or fraudulent claim or application under CRDP, or who aids and abets another in the submission of a false or fraudulent claim or application or who claims and receives duplicate benefits may be charged with a criminal offense, including an offense under 18 Pa. C.S. § 4904, relating to Unsworn Falsification to Authorities. Any person who is found guilty of such a criminal offense shall be subject to repay CRDP in full for previous services.
- I. I understand that the Department allows an appeal in the event I disagree with any decision made by the CRDP regarding my eligibility or benefits. I may appeal a decision by filing a CRDP appeal form according to its instructions.
- J. I authorize the Department of Health or its designee to act as my representative for determining my eligibility and applying for the low income subsidy of the Medicare prescription drug benefit, enrolling me in the Medicare prescription drug plan that best fits my prescription needs, handling any and all aspects of Part D on my behalf consistent with federal law, and, paying the premium of selected Medicare prescription drug plans that are less than or equal to the regional benchmark premiums.
- K. I understand CRDP may refer me to another agency to obtain health care benefits (example: Medicare, Medical Assistance) if appropriate, and that my eligibility for CRDP may be contingent upon my application for and acceptance of other appropriate health care benefits or insurance programs.

AUTHORIZED SIGNATURE

The Department of Health shall accept the Attorney-In-Fact or Court-Appointed Guardian as an authorized agent for the purpose of enrollment. Power of Attorney or guardianship documentation must be provided.