Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled

MEDICARE PART D PDP ENROLLMENT ASSISTANCE FORM

Applicant Name:	
Telephone Number:	Social Security Number:

Please choose one:

1) ☐ **If I am determined eligible for PAAD, please ENROLL me in a Medicare Part D plan for which PAAD will pay the premiums.** I have listed my medications below.

2) ☐ **If I am determined eligible for PAAD, please DO NOT switch my current Medicare Part D Plan.** I will be responsible for the premiums.

3) ☐ **I am enrolled in a Medicare Advantage plan with prescription coverage.**

4) ☐ **I have prescription coverage through a retiree or union health plan, which has notified me NOT to enroll in a Medicare prescription drug plan.** I am enclosing a copy of the notification.

☐ I CURRENTLY DO NOT TAKE ANY PRESCRIPTION DRUGS.

List the name of the pharmacy you use:

	Drug Name	Strength	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

If you need to provide additional information, please attach a piece of paper with your name, Social Security number, and additional drug names, strength, and quantity. Thank you.