DELTA COMMUNITY ACTION FOUNDATION, INC.

308 SW 2nd Street
Lindsay, OK 73052
Tel: (405) 756-1100 Fax: (405) 756-1104

Karen Nichols
Executive Director

Patient Assistance Contract

Dear Client/Patient, read each bullet before signing below:

The Prescription Assistance Program was created to ease the burden for low-income, uninsured patients, who cannot afford their prescription medicine. This program is to assist clients without **prescription drug coverage**, and is offered through Pharmaceutical companies. You will be required to complete an application and supply financial documentation to us to complete the process. While we do our best to locate assistance and secure free or discounted medications on your behalf, we ask that you do your part in supplying the necessary documentation required.

- Provide proof of income: The previous years 1040, **NOT W2**, Three Months Check Stubs, copy of SSD/SSI Benefit Statement, Unemployment/Workers Comp. Documents, TANAF, Rental income or OHCA/Sect.8 Housing Agreement, VA Benefits, Any other source of income and assets, or any Denial letters you have certifying eligibility for Medicare/Medicaid. **REMEMBER** supply **only** what applies directly to **you!**
- You must provide a copy of your Drivers License and Social Security card and any Health insurance cards you have.
- If you are not accepted into an assistance program, you will be notified, either by letter or return of the application, we should be notified as soon as this is received.
- If approved, the medication will come to your doctor's office, or your home. Medications usually come with a 90-day supply unless otherwise stated.
- You must notify our office when your medications arrive and you pick them up. No exceptions.
- You must notify the office when you are down to a 30-day supply of medication. This will ensure that you receive your refill in a timely manner; it can take as long as three weeks for a refill to be delivered. If you do not notify our office within this time frame, you may run out of your medication.
- Notify our office if your financial or insurance situation changes.
- Over-the-counter medications available at pharmacies **are not** offered by assistance programs.

We ask that you read this document carefully and sign it if you understand and agree to comply with these requirements. If you have any questions about them, please do not hesitate to ask.

Thank you for your understanding.

_____ _____

Patient Signature Date

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PLEASE PRINT ****PLEASE COPY ALL INSURANCE CARDS AND ATTACH FINANCIAL VERIFICATION****

Date: _____ **Have we assisted you before? YES NO**

Name: _____ _____ _____
(First) (MI) (Last)

Street Address: _____ **City:** _____

State: _____ **Zip:** _____ **County:** _____ **Phone:** (_____)_____

SSN: _____-_____-_____ **Sex:** _____ **Date of Birth:** _____

Household: ☐ **Head** ☐ **Spouse** ☐ **Dependent Child**

Employment Status: ☐ **Full** ☐ **Part** ☐ **Not in Labor Force** ☐ **Retired** ☐ **Unemployed**

Race: _____ **Marital Status:** _____ **Education Level:** _____

Are you a U.S. Citizen? YES NO Are you disabled? YES NO Do you have V.A. benefits? YES NO

How did you hear about this program? (Please circle one.)

Action Agency	Community Clinic	Flyer
Newspaper	Social Services	DHS
Doctor's Office	Health Department	Employer
Hospital	Other	

<u>Insurance Information</u>: Please copy and attach ALL insurance cards, front and back, including Medicare and Medicaid.

Please check all that apply:

☐ Medicare (Medicare #_____) ☐ Medicare Discount Card ☐ Medicaid

☐ Private Health Insurance (Company _____) ☐ None

Do you have prescription insurance? YES NO

Number in household: Adults _____ Children _____ **Housing:** Own Rent Stay with Family/Friends

Did you file a tax return last year? YES NO Will you file a tax return this year? YES NO

Please enter your MONTHLY household income from all sources - *Please Attach Financial Verification*

Wages $_____ Unemployment $_____ Workers Compensation $_____

Social Security Retirement $_____ Social Security Disability $_____

Other Disability $_____ Retirement $_____ Alimony/Child Support $_____

Other $_____ _____ **Total *Monthly* <u>Household</u> Income** $_____
(Specify Source)

Please list all prescriptions.

Drug Name: ______________________ Strength: __________
(e.g.: 50mg tablet)

Quantity: __________ Frequency: ____ Daily ____ Weekly ____ Monthly

Physician: ______________________

Address: ______________________ Phone: ______________________

Rx Office Use Only:
PAP:

Drug Name: ______________________ Strength: __________
(e.g.: 50mg tablet)

Quantity: __________ Frequency: ____ Daily ____ Weekly ____ Monthly

Physician: ______________________

Address: ______________________ Phone: ______________________

Rx Office Use Only:
PAP:

Drug Name: ______________________ Strength: __________
(e.g.: 50mg tablet)

Quantity: __________ Frequency: ____ Daily ____ Weekly ____ Monthly

Physician: ______________________

Address: ______________________ Phone: ______________________

Rx Office Use Only:
PAP:

Drug Name: ______________________ Strength: __________
(e.g.: 50mg tablet)

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Address: ______________________ Phone: ______________________

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PAP:

Drug Name: ______________________ Strength: __________
(e.g.: 50mg tablet)

Quantity: __________ Frequency: ____ Daily ____ Weekly ____ Monthly

Physician: ______________________

Address: ______________________ Phone: ______________________

Rx Office Use Only:
PAP:

If you have more medications than space available, please ask for an additional prescription form or attach your own sheet with the required information.

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PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give permission to authorized representatives of Rx for Oklahoma to inspect my medication records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize participating drug company(s) to discuss me and my medical needs with my physician/prescriber when necessary. This authorization is good as long as the above named program (line 1) is operational or until I revoke such.
I agree that a copy of this form can be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

Date of Birth: _____ Social Security Number: _____

Address:_____

Printed Name of Patient: _____

Signature: _____ Date: _____

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of Rx for Oklahoma to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as the above named program (line 1) is operational or until I revoke such.

Printed Name of Patient: _____

Patient Signature: _____ Date: _____

Printed Name of Advocate: _____

Advocate Signature: _____ Date: _____

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Allergy and Health Condition Information:

Client Name:_____

Client DOB:_____

Place an " X" in the box next to each allergic or health condition for which applies.

Allergic Conditions:	**"X"**
Codeine	
Sulfa	
Penicillin	
Tetracycline	
No Known Allergies	
Other (List):	
Unknown	
Health Conditions:	**"X"**
Diabetes	
Hypertension	
Heart Disease	
Glaucoma	
Stomach Disorders	
Thyroid Disease	
Arthritis	
No Known Health Conditions	
Other (List):	
Unknown	

_____

Client Signature

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RELEASE OF CONFIDENTIAL INFORMATION

The Prescription Assistance Service, ***RX for Oklahoma*****,** is designed to address the medication needs of individuals in our community. This program participates with pharmaceutical manufacturers to offer assistance and provide medications to low-income or uninsured people. These medication manufacturers often require personal demographic, therapeutic, and financial information as part of the application process. For you convenience, we are requesting your permission to access and provide the manufacturers with the requested medical and financial information, as needed.

By signing this statement you authorize the Prescription Assistance Service to complete any and all forms and applications for drug manufacturer assistance programs. This authorization may be revoked at any time by contacting RX for Oklahoma prescription assistance program. The individual signing this document reserves the right to appeal any decision made regarding assistance provided by RX for Oklahoma participating partners. The right to appeal does not guarantee the right to modify individual pharmaceutical company policies and procedures.

_____	_____	_____
(Client signature)	(Date)	(Client signature Printed)
_____	_____	_____
(Witness For the Agency)	(Date)	(Witness Signature Printed)

****Administrative Use Only****

Address and Telephone Number of the CAA office/center or Partnering Clinic where this statement was signed

_____

(Facility Name) (Address) (Phone)