Regional Healthcare Foundation

Prescription Drug Assistance Program

215 W. Grant Street, Dexter, MO 63841
Phone: 573-624-1607 ♦ Fax: 573-614-4908

READ THOROUGHLY
PAGES 1 & 2 ARE INFORMATIONAL. PLEASE RETURN PAGES 3 - 6 FOR PROCESSING

- If you have MEDICAID without a “spend-down” or have any other PRESCRIPTION DRUG COVERAGE, you do no qualify for Prescription Drug Assistance. If you have a “spend-down” you will likely qualify for the program.
- If you are enrolled in MEDICARE PART D, you are not eligible for this program, unless you are in the coverage gap known as the “donut hole.” However, you may qualify if Part D will not cover some of your medicines. This determination is made on a case-by-case basis.

If you, or your healthcare provider, have requested assistance with your medications, please read the following information. The information below is an outline of how the PRESCRIPTION DRUG ASSISTANCE PROGRAM works. The form attached is the application that you need to complete and return to the address above.

- Completely fill out the Patient Information Form and mail back to us. If you need help filling out your information form, please let us know. We will be glad to help you.

- The PRESCRIPTION DRUG ASSISTANCE PROGRAM staff will review your medications and locate any programs available through the pharmaceutical companies.

- To qualify you must be within specific income limits and provide the appropriate proof of income.

- We will process an Rx Company application for each of the medications we are ordering for you. We will then mail each of them to you for your signature. You will then return them to us in the self-addressed envelope, enclosed for your convenience. After you have returned the Rx application with your signature, we will then send all applications to your healthcare provider for his/her signature.

- Once your healthcare provider returns your Rx applications and prescriptions, we will attach other essential documents to your Rx applications and mail or fax them to the Rx Companies. BE PATIENT. In general, it will take the pharmaceutical companies approximately two to six weeks to process your applications and send your medicine. Your medicines will either be delivered to your address or will be sent to your healthcare provider for you to pick up. Remember, each Rx Company has their own policy on how they deliver medications to you.

- Most Rx applications for patient assistance must be renewed every three months.

WE WILL NEED ESSENTIAL DOCUMENTATION FROM YOU AND INCOMPLETE APPLICATIONS WILL BE RETURNED

PLEASE REFERENCE THE ESSENTIAL DOCUMENTS NEEDED ON PAGE TWO.

DOCUMENTATION NEEDED

Please provide the following documentation for our records if applicable to you. These documents are required by the various pharmaceutical companies who provide your medications.

- 2009 Income Tax Return (if you are required to file taxes)
- Pay Stubs for the most recent month
- Unemployment Benefit Statement
- 2009 Social Security Form 1099
- 2010 Benefit Statement letter from Social Security
- Medicaid Denial Letter and/or “Spend-down” notification
- Part D "DoNut Hole" Deductible Insurance Verification
- Interest Income 1099 Form(s)
- Pension Income 1099 Form(s)
- Medicare Card
- Social Security Card
- Medicare Supplement Card
- Drivers License or other photo ID
- Any other documents that show income you received

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THE FOUNDATION'S PRESCRIPTION DRUG ASSISTANCE PROGRAM IS NOT A SUBSTITUTE FOR AND IS NOT ASSOCIATED WITH THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM. IF YOU ARE ELIGIBLE FOR PART D AND YOU DO NOT ENROLL IN THAT PROGRAM WITHIN THE TIME REQUIRED, YOU MAY HAVE TO PAY A HIGHER PREMIUM, IF YOU LATER ENROLL IN PART D.

PATIENT INFORMATION FORM MUST BE COMPLETED ENTIRELY

Today's Date: ______________________ Referred by: __________________________

PATIENT INFORMATION (Please PRINT all information)

First Name: ______________________________ M _______ Last ________________________________

Home Telephone: ____________________Work ___________________Message ___________________

Mailing Address:____

Street or County Road Address: ____

City: _______________________State: _________ County: ___________________ Zip: _____________

PERSONAL INFORMATION

Date of Birth: ______________________________ SSN: ___________ - ____________ - _____________

Circle One: Male or Female

US Citizen Yes No US Resident Yes No US Veteran Yes No

Marital Status: Circle One

Single Married Divorced Widow Other ___________________

Employment Status: Circle One

Employed Self-employed Unemployed Retired Other ___________________

Race (Optional) _____________________ Spouse's Name: ______________________________________

Contact Person___________________________ Relationship ________________Phone # _____________

Number in Household (including patient) _____ Number of children in household under the age of 18 ________

Did you file Income Taxes for 2009? ___Yes ____No

INSURANCE INFORMATION Circle either Yes or No

Do you have ANY prescription drug coverage? Yes No

Amount of monthly out of pocket medical expenses:____
(Prescription or over-the-counter medication costs, hospital or physicians bills, etc. includes anything actually paid out of the patients pocket)

Do you have Medicare? Yes No Medicare Claim # ____

If yes, have you applied for Low Income Subsidy (LIS) from Social Security? Yes No

Have you enrolled in Medicare Part D? Yes No

If "Yes" are you in the Part D DoNut Hole Deductible? Yes No

Do you have a Medicare Supplement? Yes No

Company Name & Policy # of Supplement: ____

Do you have Medicaid? Yes No If yes, does it cover ANY prescriptions? Yes No

Do you have a spend down? Yes No

Have you applied for Medicaid (in the last 2 years) and have been denied? Yes No
(If yes please send a copy of the denial letters)

Are you legally disabled? Yes No What date were you declared legally disabled? ____________________

HEALTHCARE INFORMATION

Name: ____

Medical Condition(s):

____

Drug allergies:

____

Doctor's Name (first & last)	Name of Facility	Address	City, State, Zip	Telephone #/Fax #

Name Brand of PRESCRIPTION Medication (not the GENERIC)	Strength	# of times daily	Doctor	Status (Office use only)	Rx Co (Office use only)

Continue on back of page, if necessary

X____ X____________________

Signature of Participant Date

By signing this application you agree that all the information you have provided is correct. You also agree that you are responsible for reporting any changes in your financial situation or insurance coverage.

AUTHORIZATION FOR THE USE OF DISCLOSURE OF INFORMATION TO REGIONAL HEALTHCARE FOUNDATION – PRESCRIPTION DRUG ASSISTANCE PROGRAM

PARTICIPANT INFORMATION:______________________________Social Security Number: ________________________

Name: ____ Date of Birth: ___________________________

Address:____

Purpose of Request: Information obtained by using this Authorization will be furnished to and used by **Regional Healthcare Foundation** to determine my eligibility for participation in the **Prescription Drug Assistance**, a program designed to assist participants in locating prescription drug programs made available by pharmaceutical companies and others whereby participants can obtain their prescriptions for free or below customary market costs and to assist participants in making application to such providers.

To the Participant: In order to determine your eligibility for the Project and to administer your participation in the Project, if accepted, Regional Healthcare Foundation will need to obtain certain information about you from your doctor and be authorized to relay this information to the Pharmaceutical company/companies providing patient assistance with free or below market cost medications. **The Regional Healthcare Foundation** agrees that they will only use this information to determine your eligibility for this Project, to administer the Project and to account for your withdrawal if you decide to stop participating in this Project. Please complete this Authorization for the disclosure of information in connection with the Project.

I request and authorize my doctor "Doctor" who is ____and whose address is: ____to release and give to the Regional Healthcare Foundation, including representatives who work on their behalf, information about me and my medical condition, which is necessary to determine my eligibility for the Project if I am accepted. The type of information that may be given under this authorization includes:

- My name and birth date
- My address and telephone number
- Billing information about me
- Information about my health benefits or health insurance coverage
- Information on my medical condition, which indicates that the use of the requested medicine is medically necessary.

If my medical record contains information about drug and/or alcohol abuse, mental health or genetic information, I agree that its release to the **Regional Healthcare Foundation** for the purposes above stated.

I authorize the release of my medical records created both before and after the date I sign this Authorization. I understand that I can inspect a copy of the protected health information that is to be used or disclosed.

I understand that I need to sign this Authorization to take part in this **Prescription Drug Assistance Program**. If I do not sign this Authorization, my decision will not affect my ability to obtain assistance from a health care provider of my choice or to seek assistance from other sources.

I understand that I can cancel this Authorization at any time by writing to my Doctor at his/her address as set forth above. If I do so, I will send a copy of this writing to the Regional Healthcare Foundation. If I cancel this Authorization, then my Doctor will stop providing the **Regional Healthcare Foundation** and their representatives with information about me. However, I cannot cancel actions that have already been taken by relying on my Authorization.

I understand that once my Doctor gives **the Regional Healthcare Foundation** information about me based on this authorization, federal privacy laws may not prevent Regional Healthcare Foundation from further disclosing my information and that the Regional Healthcare Foundation, its affiliates', employees, officers, and directors are not legally responsible or liable for the re-disclosure of the information on this Authorization.

I understand that signing this authorization does not guarantee that I will be accepted into any prescription drug assistance program that the Foundations' Prescription Drug Assistance may locate for me.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicine under the Project, whichever is later.

I UNDERSTAND THAT THE FOUNDATIONS PRESCRIPTION DRUG ASSISTANCE PROGRAM IS NOT A SUBSTITUTE FOR MEDICARE PART D PRESCRIPTION DRUG COVERAGE AND IF I DELAY ENROLLING IN PART D, I MAY INCUR A PREMIUM PENALTY.

____ ____
Participant Signature Dated

____ ____
Print Participant Name Authority to sign on the BEHALF of Participant