DOCUMENTATION NEEDED WITH COMPLETED Rx APPLICATION

- **Drivers License (Picture ID)**
- **Social Security Card**
- **Insurance Card(s) (if applicable)**
- **Federal Income Tax Return (1040)**
- **1099 from Social Security (if applicable)**
- **30 day Income Verification (Check stubs, Social Security income letter, etc.)**
- **SoonerCare (Medicaid) Denial Letter (if applicable)**

Sharee Smith, Program Coordinator

Community Action Development Corp.
105 S. Main / PO Box 989
Frederick, OK 73542
Phone: 580-335-5588
Toll Free: 877-794-6552
Fax: 580-335-3092
E-mail: shareesmith@pldi.net

For faster service, please call for an appointment!

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PLEASE PRINT ***MUST PROVIDE COPY OF INS. CARDS AND FINANCIAL DOCUMENTATION TO PROCESS****

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

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

Street/Mailing Address: _____ **City:** _____

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

SSN: _____ - ____ - _____ **Sex:** _____ **Date of Birth:** ____/____/____ **Language:** _____

Household: ☐ Head ☐ Spouse ☐ Dependent Child

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

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

U.S. Citizen? YES NO U.S. Resident? YES NO Disabled? YES NO Veteran? YES NO

***How did you hear about the RX program? _____

Insurance Information: PLEASE COPY AND ATTACH ALL INSURANCE CARDS, FRONT AND BACK.

Please check all that apply:

☐ Medicare (Medicare #_____) Are you eligible for Medicare Part D? YES NO
Effective Date: Part A_____ Part B____

☐ SoonerCare (Medicaid)

☐ Private Health Insurance (Company _____ _____)

☐ None

Do you have prescription insurance? YES NO

Have you applied and/or been denied for SoonerCare (Medicaid) in the past 12 months? YES NO

If yes, please include copy of denial letter.

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

Salary/Wages $_____ Unemployment/Work Comp. $_____ SSD/SSI $_____

Social Security Retirement $_____ Alimony/Child Support $_____ Pension/Retirement $_____

Other $_____ **Total *Monthly* Household Income $**_____

Please verify above information is true and correct _____ Date _____

(Applicant signature)

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Release Form

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 your convenience, we are requesting your permission to access and provide the manufacturers with the requested medical and financial information, as needed.

Exchange of Information

I, _____ give authorization to the representatives of the 'Rx for Oklahoma PAP' to inspect my medication records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture and/or provide medications through patient assistance programs. I also authorize participating drug company(s) to discuss me and my medication needs with my physician/advocate when necessary. This authorization is active until such time as I revoke this authorization.

*****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 and/or organization individually to give them information about me that they may need.

Date of Birth: _____ Social Security #: _____

Address: _____

Printed Name of Patient: _____

Signature: _____ Date: _____

This program is provided through a joint effort of Great Plains Improvement Foundation and the Oklahoma Department of Commerce, and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

Primary Physician Information:

Physician Name: _____ Phone: (_____)_____

Street Address: _____

City: _____ State: _____ Zip: _____ Years with Physician: _____

Please list all prescriptions.

*****If medication was prescribed by a different physician than the one listed above, circle "NO" and complete the new physician information.**

PRESCRIPTION 1 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____)_____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 2 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____)_____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 3 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____)_____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 4 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 5 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 6 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 7 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 8 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

PRESCRIPTION 8 _____ Strength: _____ Frequency: _____

Primary Physician YES NO

Physician Name: _____

Address _____

Phone (_____) _____

RX Office Use Only
PAP: _____
Phone: _____

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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Allergy and Health Information

Client Name: _____ **DOB:** _____

Place an 'X' in the box next to each allergy or health condition which applies to you.

Medication Allergies	
Codeine	
Sulfa	
Penicillin	
Tetracycline	
NO KNOWN ALLERGIES	
Other (please list)	
1.	
2.	
Food Allergies (please list)	
1.	
2.	
Health Conditions	
Diabetes	
Hypertension	
Heart Disease	
Glaucoma	
Stomach Disorders	
Thyroid Disease	
Arthritis	
NO KNOWN HEALTH CONDITIONS	
Other (please list)	
1.	
2.	

Patient Assistance Contract

Dear Client/Patient:

Certain pharmaceutical companies offer patient assistance programs to patients without prescription insurance coverage and/or cannot afford their medications and qualify under specific guidelines. The **Rx for Oklahoma staff** is here to **assist** with all the paperwork involved in the attempt to get you the assistance needed. You may be required to complete an application and/or answer questions by either the company and/or our staff. While we do our best to locate assistance, we ask that you do your part in supplying the necessary documentation required to complete the applications in a prompt and efficient manner. We will try our best to secure free or discounted medications on your behalf; however, each pharmaceutical company has its own policy and financial guidelines that we must follow. Below are just a few of the items that we expect from you:

- **Provide proof of income for as long as you are requesting assistance**. This can be a copy of last year's tax return, a copy of your statement of benefit from Social Security, Letters on letterhead from your employer, or other documentation as the pharmaceutical company stipulates.
- ***Notify the office when/if the telephone or address changes for you or your physician.***
- **If you are accepted** into an assistance program, your medications will ship either to your doctor's office, your pharmacy or your home and you may be required to sign for it. Medications usually ship in a 90-day supply or less. **If you are NOT accepted** into an assistance program, you will be notified. Most companies notify with a denial letter sent to both you and your physician.
- **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, since it can take the pharmaceutical company as long as three to four weeks to issue a refill. If you do not notify our office within this time frame, you may run out of your medication.
- **Notify our office** if/ when your financial or insurance situation changes.
- **Notify our office** of any changes to your medications (no longer taking, dosing changes, etc.).
- **Notify our office** of any mailings you receive from the pharmaceutical companies. These notices are received by the patients or physicians only.
- **Name and point of contact of an individual** we can contact if you are unable to be reach.

Name	Telephone number	Relationship

Please keep in mind that we strive to do our very best with making sure your medications are received in a timely matter, but ultimately it is **your** responsibility as the *Patient/Client* to ensure that you receive your medications. We ask that you read this document carefully and sign it if you understand and agree to comply with these requirements. A copy of this signed contract will be provided to you. Please call our office if you have any questions.

Thank you for your understanding.

Patient Signature _____ Date _____

Revised 7/22/2014 cjc

Community Action Development Corporation

Service Provided	RX For Oklahoma

105 South Main Frederick, OK 73542
Phone (580)3355588 Fax (580) 3353092

Brent Morey
Executive Director

CUSTOMER INFORMATION

Last Name	First Name	Date of Birth	Today's Date
Phone ( )	Email	SSN (last 4 digits)	Office Location
Address	City		Zip Code

GENDER	MARITAL STATUS	ETHNICITY
☐ Male ☐ Other	☐ Single ☐ Separated	☐ Hispanic/Latino
☐ Female	☐ Married ☐ Divorced	☐ Non-Hispanic/Latino

INDICATE YOUR RACE (SELECT ONE)

☐ American Indian/Alaskan Native	☐ Caucasian (White)	☐ Other
☐ Asian	☐ Hawaiian/Pacific Islander	
☐ Black/African American	☐ Multi-Race	

INDICATE YOUR EDUCATION (SELECT ONE)

☐ 0-8th Grade	☐ 12+ Some Postsecondary	☐ Graduate of other post-secondary school
☐ 9-12th/Non-Graduate	☐ 2 or 4 year College Graduate	
☐ High School Graduate/GED		

INDICATE YOUR HEALTH INSURANCE (SELECT ONE)

☐ No Health Insurance	☐ Medicaid	☐ Sooner Care
☐ Direct Purchase	☐ Medicare	☐ Indian Health Services
☐ Employment Based	☐ Military Health Care	

MILITARY STATUS (SELECT ONE)	ARE YOU DISABLED?	Education/Employment Status
☐ Active Military ☐ No Status	☐ Yes	☐ Not Working/Not in School
☐ Veteran	☐ No	☐ Working/Not in School
		☐ In School/Not Working

WORK STATUS (SELECT ONE)		DO YOU HAVE A CDIB CARD?
☐ Employed Full-Time	☐ Unemployed Short Term >6mos	☐ Yes
☐ Employed Part-Time	☐ Unemployed (Long-Term)	☐ No
☐ Migrant Seasonal Farm Worker	☐ Unemployed (Not in Workforce)	
☐ Retired		

NON-CASH BENEFITS (SELECT ONE)

☐ Affordable Care Act Subsidy	☐ LIHEAP	☐ None-No Need
☐ Childcare Voucher	☐ TANF	☐ None-Not Eligible
☐ SNAP (Food Stamps)	☐ WIC/Tribal WIC	
☐ Section 8 Housing	☐ Indian Commodities	

INDICATE YOUR MONTHLY INCOME AMOUNT AND SELECT INCOME SOURCE:	$

☐ Employment	☐ None	☐ Social Security
☐ TANF	☐ Pension	☐ SSDI
☐ Public Assistance	☐ Alimony	☐ SSI
☐ Child Support	☐ Rental	☐ Veterans
☐ Self-Employment	☐ Interest/Dividends	☐ Work Comp

HOUSING STATUS (SELECT ONE)

☐ Rent	☐ Homeless	☐ Other Permanent Housing
☐ Own	☐ Other	

HOUSEHOLD TYPE (SELECT ONE) PLEASE CIRCLE

SINGLE PERSON MALE SINGLE PARENT FEMALE SINGLE PARENT NON-RELATED ADULTS W/CHILDREN
W/O ADULTS NO CHILDREN TWO PARENT HOUSEHOLD OTHER

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Enclosed you will find the application along with instructions that you have requested through the Patient Assistance Program. You will need to check over the application and make sure that everything is filled in correctly and fill in what is blank. Then take the application to your doctor and he or she will need to sign and give you prescriptions for the medications that you have requested. **Make sure that the prescriptions are written for 3 months with a years worth of refills. Some need to be written for a 6 month supply and they are specified on the information sheet.** Then you will need to return everything back to me and I will mail it off for you. If you have any questions fill free to give me a call at the phone number above.

Thank you,

Sharee Smith

Sharee Smith
Rx Coordinator
Rx for Oklahoma

Please make
Sure All
Prescriptions a
written for a
3 month refi
Supply.