REGIONAL HEALTHCARE FOUNDATION

…**a vision of healthy people living in healthy communities**

Prescription Drug Assistance Program

215 W. Grant, Dexter, Missouri 63841

Telephone: 573-624-1607 Fax 573-614-4908

www.regionalhf.org

ATTENTION: NEW PATIENTS

Please allow 4 to 6 weeks to receive your **"FIRST"** fill on your prescriptions.

Regional Healthcare does "not" determine where medication(s) will be shipped. The pharmaceutical company which supplies the "free" medication(s) determines the date of shipment and place of delivery.

THIS IS HOW THE PRESCRIPTION DRUG ASSISTANCE PROGRAM WORKS:

Step 1 - You will receive an application(s) to sign and return to RHF.

Step 2 - We will handle processing for application with your doctor.

Step 3 - We will process the application with all necessary documents to the pharmaceutical company.

Step 4 - Once the pharmaceutical company processes your application, they will send your medicine either to you or to your doctor. You will receive a "**GREEN**" postcard from Regional Healthcare Foundation with delivery information each time your medication is ordered.

Step 5 - Report Medication(s) received - **You must report the date you receive your medication to Regional Healthcare Foundation (by phone or mail the "green" postcard to the office). When you report the date, you receive medication(s), the next refill date will be set. We cannot process any refills without this information.**

After first order, refills will arrive in 7 to 10 days from the time they are processed.

If you need assistance filling out this application, please come by our office. We will be happy to assist you.

***This program is not a substitute for those who are eligible for Medicare Part D, Medicaid or Health Insurance. You may qualify for assistance if medications are not covered by these programs, have high Medicaid spenddown, have high co-pay on prescription insurance or have reached Medicare Part D coverage gap (Donut Hole).**

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Website: www.regionalhf.org

INFORMATION SHEET MUST BE COMPLETED ENTIRELY

Today's Date_____ Referred By: _____

PATIENT INFORMATION (PLEASE PRINT ALL INFORMATION)

First Name:_____M_____Last_____

SSN: _____-_____-_____

Home Telephone _____Work _____Cell_____

Mailing Address: _____

Home Address: _____

City_____ State _____ County_____ Zip _____

PERSONAL INFORMATION

Date of Birth _____ Circle One: Male or Female

United States Citizen _____Yes _____No

United States Resident _____Yes _____No

United States Veteran _____Yes _____No

Do you have Veterans Benefits ____Yes ____No

DISABILITY:

Have you applied for Disability? ____Yes _____No (If "No" Skip to next Section)

What is the status of your application? _____Approved _____Denied _____Pending

If approved, what is the date you were declared legally disabled? _____

MARITAL STATUS: Circle One

SINGLE MARRIED DIVORCED WIDOW OTHER _____

Spouse's Name_____ Race (Optional)_____

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

EMPLOYMENT STATUS: Circle One

Employed Self-employed Unemployed Retired Disabled Other

Did you file Federal Income Taxes for 2018? ___Yes ___No If **YES** send copy of your signed tax return

ASSISTANCE:

Have you ever participated in a Prescription Drug Assistance Program? _____Yes _____No

If yes, what was the name of the program and when? _____

I permit Regional Healthcare Foundation Prescription Drug Assistance Staff to speak with the following person(s) about the information on this application.

Contact _____Relationship _____ Phone# _____

Contact _____Relationship _____ Phone# _____

Patient Signature:_____Date:_____

****Complete Information on Back Side of Form***

Revised 07/9/2019

Patient Name: _____

DOCUMENTS REQUIRED: *NOTE: DOCUMENTS MUST BE SENT, OR APPLICATION WILL BE RETURNED.

- ✓ Driver's License or another photo ID – for patient only

PROOF OF INCOME: Please include income for all persons in the home

- ✓ 2018 **Federal** Income Tax Return (Page 1 and 2 **signed** and **dated**) and any page of your Return which shows the following headings at the top of the page: (Do not send State Tax Return)
  - Health Coverage Exemption
  - Affordable Care Worksheet
  - Marketplace Coverage Exemption
- □ If no tax return, you may provide the following:
  - Pay Stubs for most current month
  - Current Year W-2's
  - Unemployment Benefit Statement
  - 2019 Benefit Statement letter from Social Security
  - Interest Income 1099 Form(s), Pension Income 1099 Form(s)
- □ **Zero Income Patients –** Patients must write a personal letter explaining financial situation and how you support yourself. **Letter must be signed and dated.** If someone is helping you financially, explain relationship to person helping you and how they assist you.

INSURANCE INFORMATION:

Do you have any form of prescription drug coverage? ____Yes ____No (If "No" Skip to next Section)
If yes, provide copy of insurance card (front and back)
If yes, does your insurance have: _____High copays/deductibles _____Medication not covered?

MEDICARE INFORMATION:

Do you have Medicare A & B? _____Yes ____ No Medicare Part D? _____Yes _____No
If "No" Skip to next Section. **If yes, send a copy of any insurance cards front and back.**
If you have Medicare Part D, send a copy of your most recent monthly Part D Statement as well as a pharmacy printout for the current calendar year showing how much has been spent on prescriptions.

Have you applied for "Extra Help" benefits from Social Security? ____Yes ____No
If yes, provide a copy of your **FINAL** Decision Letter from Social Security verifying your status for "Extra Help" benefits. **If No,** please apply for the "Extra Help" program through Social Security by calling **1-800-772-1213**, online at www.socialsecurity.gov/extrahelp or by visiting your local Social Security Office. *All Medicare patients **must** apply for "Extra Help" from Social Security.

MEDICAID:

Do you have Medicaid/Missouri Health Net? ____Yes ___No
If yes, send a copy of card front and back
Have you been denied for Medicaid in the last two years? ___Yes ___No
If yes, provide a copy of your Medicaid denial.
If approved for Medicaid, do you have a Spenddown? ___Yes ___No
If yes, provide letter verifying the amount of your monthly Spenddown.
If yes, have you met your Spenddown in the last 6 months? ___Yes ___No
If yes, does Medicaid/Missouri Health Net cover **any** prescriptions? ___Yes ___No
Is Medicaid for Women's Wellness Program only? ___Yes ___No

LIST CURRENT MEDICATIONS and DOCTORS BELOW

Healthcare Information

Name_____

Medical Conditions_____

Drug allergies_____

***DO NOT LIST PHYSICIANS FROM EMERGENCY ROOM SERVICES or URGENT CARE PHYSICIANS**

Current Doctor's Name (first & last) Title (Dr., FNP, etc…)	**Name of Facility, Address and City, State, Zip**	**Telephone #**
	Name of Facility: Address:	Phone: Fax:
	Name of Facility: Address:	Phone: Fax:
	Name of Facility: Address:	Phone: Fax:

***Be very specific with medication dosages and directions- This section must be filled in completely.**
List one medication per line - additional space on backside of page

List All Current Medications	***Strength**	**# of times daily *Be Specific**	**Doctor Prescribing Medication**	**Office use only**	**Pharmaceutical Co. (office use only)**

***Be very specific- Insulin Dosages need to include number of UNITS,**
how many times you inject and max units per day.
Inhaler Dosages need to include how many puffs (inhalations) and how many times a day.

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.

Revised 07/09//2019

Patient Name: _____

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