

# 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](http://www.regionalhf.org)

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## ATTENTION: NEW PATIENTS

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

Regional Healthcare does “not” control shipments of medication. 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 - We mail you the applications to sign and return to Regional Healthcare Foundation.
- Step 2 - We mail the applications and prescriptions to your doctor to sign and return to Regional Healthcare Foundation.
- Step 3 - We mail the application, prescription, proof of income and required 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.**

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# Regional Healthcare Foundation

## Prescription Drug Assistance Program

215 W. Grant Street, Dexter, MO 63841  
573-624-1607

Website: [www.regionalhf.org](http://www.regionalhf.org)

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.

### INFORMATION SHEET MUST BE COMPLETED ENTIRELY

Today's Date \_\_\_\_\_ Referred By: \_\_\_\_\_

#### **PATIENT INFORMATION** (PLEASE PRINT ALL INFORMATION)

First Name: \_\_\_\_\_ M \_\_\_\_\_ Last \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

#### **PERSONAL INFORMATION**

Date of Birth \_\_\_\_\_ Circle One: Male or Female

United States Citizen \_\_\_\_\_ United States Resident \_\_\_\_\_ United States Veteran \_\_\_\_\_  
\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ 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 \_\_\_\_\_

Contact Person: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

#### **EMPLOYMENT STATUS:** Circle One

Employed Self-employed Unemployed Retired Disabled Other

Did you file\will you file Federal Income Taxes for 2017? \_\_\_\_ Yes \_\_\_\_ No If yes send copy of Tax Return

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

Revised 01/19/2018

**Patient Name:** \_\_\_\_\_

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

- ✓ Drivers License or other photo ID – for patient only

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

- Signed/Dated** 2017 **Federal** Income Tax Return – (Please do not send State Tax Return)
- If no tax return, you may provide the following:
  - Pay Stubs for most current month
  - Current Year W-2's
  - Unemployment Benefit Statement
  - 2018 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 this calendar year showing how much you have spent on prescriptions.

\*All Medicare patients must apply for "Extra Help" from Social Security. Send a copy of your "Final Decision" letter to our office.

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](http://www.socialsecurity.gov/extrahelp) or by visiting your local Social Security Office.

**MEDICAID:**

Do you have Medicaid/Missouri Health Net? \_\_\_Yes \_\_\_No (If "No" Skip to next Section)

**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

**ASSISTANCE:**

Have you ever participated in a Prescription Drug Assistance Program? \_\_\_Yes \_\_\_No

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

**LIST CURRENT MEDICATIONS and DOCTORS BELOW**

**Healthcare Information**

Name \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Drug allergies \_\_\_\_\_

**\*DO NOT LIST PHYSICIANS FROM EMERGENCY ROOM SERVICES**

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**

List All Current Medications	*Strength	# of times daily	Doctor	Office use only	Rx Co (office use only)

**\*Be very specific with Insulin Dosages – Units daily and when you inject**

X \_\_\_\_\_  
Signature of Participant

X \_\_\_\_\_  
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.**

