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" 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.

Regional Healthcare Foundation

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573-624-1607

Website: 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

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 2016? ___Yes ___No If yes send copy of Tax Return

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

Revised 05/10/2017

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** 2016 Federal Income 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
  - 2017 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**
Are you in the Deductible Coverage Gap known as the "DoNut Hole"? _____Yes _____No
If yes, provide a copy of Prescription Part D monthly statement to verify coverage gap
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.

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? _____

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_____ 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.

Patient Name: _____

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