…a vision of healthy people living in healthy communities
215 W. Grant, Dexter, Missouri 63841
Telephone: 573-624-1607 Fax 573-614-4908

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.

This 4 step process takes 4 to 6 weeks for “first” orders.

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

You must always report the date you receive your medication to Regional Healthcare Foundation (by phone or mail the “green” postcard to the office). This notification sets the date for your next refill.

Regional Healthcare Foundation

Prescription Drug Assistance Program
215 W. Grant Street, Dexter, MO 63841
573-624-1607

Website: regionalhf.org
Email: rhfprescriptions@sbcglobal.net

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 _______________Message/Cell_______________

Mailing Address:____

Physical Address: ____

City________________________ State _______ County____________________ Zip ____________

PERSONAL INFORMATION

Date of Birth ________________________ Circle One: Male or Female

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

Have you applied for Disability**?** **Yes No** Status of your application?______________________

Date were you declared legally disabled____________ Do you receive Disability Income? ______

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# _______________

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

Revised: 06/28/2016

Patient Name: ____________________________________

EMPLOYMENT STATUS: Circle One

Employed   Self-employed   Unemployed   Retired   Disabled   Other

Did you file Federal Income Taxes for 2015? **Yes** **No** If yes send copy of Tax Return
Did anyone claim you on their 2015 Taxes? **Yes** **No** If yes send copy of Tax Return

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

- ✓ Social Security Card **–** for patient only **- Required**
- ✓ Drivers License or other photo ID **–** for patient only- **Required**

- **Send Following if applies to you:**

- ☐ Medicare Card, Medicare Supplement Card, Medicare Part D card- Front and Back
- ☐ Part D DoNut Hole Verification From Insurance
- ☐ Disability Award Letter
- ☐ Any Insurance card - Front and Back
- ☐ Missouri RX Card – Front and Back
- ☐ Medicaid Card – Front and Back, Medicaid Denial Letter, Spend-Down Letter

- **Proof of Income: Please include income for all persons in the home**

- ☐ **Signed/Dated** 2015 Federal Income Tax Return with W-2's, 1099's etc.- **REQUIRED if taxes were filed**
- ☐ Pay Stubs for most current month (persons who do not file taxes)
- ☐ Unemployment Benefit Statement
- ☐ 2015 Social Security Form 1099
- ☐ 2016 Benefit Statement letter from Social Security
- ☐ Interest Income 1099 Form(s), Pension Income 1099 Form(s)
- ☐ Child Support/Alimony
- ☐ Any other documents that show income you have received
- ☐ **Zero Income Patients** – Must write a personal letter explaining financial circumstances and how you support yourself. **Letter must be signed and dated.**

INSURANCE INFORMATION **Circle either yes or no**

Do you have private prescription drug coverage (including Employer sponsored plans, etc)? **Yes or No**

Do you have Health Insurance through the Marketplace Plan/Exchange (Obama Care) **Yes or No**

Do you have Medicare A & B? **Yes No** Do you have a Medicare Supplement? **Yes No**

Company Name & Policy # of Supplement ____________________________________

Have you applied for "Extra Help" from Social Security? **Yes No** **(If yes, please send Denial or Approval Letter)**

Have you enrolled in Medicare Part D? **Yes No** Are you in Medicare Part D DoNut Hole? **Yes No**
(**if Yes send document to verify**)

Do you have Medicaid/Missouri Health Net? **Yes No** Do you have a spend-down? **Yes No**
If yes, does it cover ANY prescriptions? **Yes No** **(If yes to spenddown, send document showing amount)**
Is Medicaid for Women Wellness only? **Yes No** Is Medicaid for Food Stamps Only? **Yes No**
Have you met your spend-down in the past 6 months **Yes No**
Have you applied for Medicaid (in the last 2 years) and have been denied? **Yes No** **(If yes, please send copy of denial letter.)**

Do you now or have you in the past received assistance from Prescription Drug Assistant Programs? ______________

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:	
	Name Of Facility: Address:	

(Current Medications Only) Name Brand of PRESCRIPTION Medication (not the GENERIC)	*Strength	# of times daily	Doctor	Status (office use only)	Rx Co (office use only)

***Be very specific with Medication Dosages and directions – Insulin dosages should include max dose**

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.

(Current Medications Only) **Name Brand of PRESCRIPTION Medication (not the GENERIC)**	**Strength**	**# of times daily**	**Doctor**	**Status (office use only)**	**Rx Co (office use only)**