114 S Independence Ave.
Enid, OK 73701
580-242-7928 Fax 580-234-3554
www.cdsaok.org

RX FOR OKLAHOMA

This program is to assist client/patients without prescription drug coverage. These programs offer client patient maintenance drugs by Pharmaceutical Companies for the "medical needy". The Prescription Assistance Program was created to make it easier for uninsured or underinsured patients to get free or nearly free prescription medicine. Each patient assistance program has its own eligibility criteria. In addition to prescription benefits status (any prescription drug coverage or eligible for coverage) household income and size, the criteria for some programs require additional information.

Information Necessary for Application

Please provide the following information to process the application.

- Application Form
- Prescription Form
- Patient Consent and Release Form
- Information Form
- Proof of Income
  - ❖ 1 months pay stubs, if employed
  - ❖ Most recent income tax return
  - ❖ Unemployment/workers comp. Documentation
  - ❖ SSR, SSI, SSD, Pension/Retirement
  - ❖ Public Assistance (TANF)
  - ❖ Rental Income
  - ❖ Veteran's benefits or other course of income
- Any Insurance Cards, copy of front and back, to include health insurance and/or prescription coverage, Medicaid or Medicare.
- Denial Letter certifying ineligibility for Medicare/Medicaid, state health insurance, veterans or any other health insurance coverage.

**Note: Please mail back the highlighted or marked information to our office.

If you do not have an income, please write a statement explaining your current situation.

Thank you,

Rx for Oklahoma Staff

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Dear Client:

Certain pharmaceutical companies offer patient assistance programs to patients without prescription insurance coverage and/or cannot afford their medications and qualify under specific guidelines. Our program will handle the majority of the paperwork for you. You may be required to complete an application or answer a few questions by either the pharmaceutical company or our program.

While we do our best to locate assistance, we ask that you do your part in supplying the necessary documentation required to complete the application 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 it own policies and financial guidelines that we must adhere to. Below are a few of the things that we expect from you to help with the process:

- Provide proof of income. This can be a copy of last year's tax return, a copy of your Social Security benefit statement, copies of your last four pay stabs or documentation that the pharmaceutical company stipulates.

- If you are not accepted into an assistance program, a denial letter will notify you. If approved, the medication will be shipped directly to your home or to your doctor's office and you will have to sign for it. Most medication is for 90-days or less.

- Notify our office when you have a 30-day supply of medication. This will ensure that you receive your refill in a timely manner. It can take the pharmaceutical company as long as four weeks to issue a refill. If you do not notify our office within this time frame, you may run out of medication.

- Notify our office if your financial or insurance situation changes.

- Over the counter medications **are not** offered by the assistance programs.

We ask that you read this document carefully and sign if you understand and agree to comply with these requirements.

_____ _____

Client Signature Date

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Rx for Oklahoma

Patient Consent and Release Form

Exchange of Information

I give permission to authorized representatives of Rx for Oklahoma to inspect my medication records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize participating drug companies to discuss my medical needs with my physician/prescriber when necessary. This authorization if good as long as the above named program is operational or until I revoke such.

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 or organization individually to give them information they may need.

Date of Birth: _____ Social Security Number: _____

Address: _____

Printed Name of Client: _____

Signature: _____ Date: _____

Patient Signature Authorization

I authorize representatives of Rx for Oklahoma to sign forms on my behalf for the purpose of soliciting medications from companies that manufacture or provide medications through patient assistance programs. This signature is good as long as the above names program is operational or until I revoke such.

Printed Name of Client: _____

Patient Signature: _____ Date: _____

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Release of Confidential Information Form

The **Prescription Assistance Service, *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.

By signing this statement you authorize the Prescription Assistance Service, *RX for Oklahoma,* to complete any and all forms and applications on your behalf, and to access and release any personal demographic, therapeutic, and/or financial information relating to applications for drug manufacturer assistance programs. This authorization may be revoked at any time by contacting **CDSA**, the Prescription Assistance Service, *Rx for Oklahoma*, at 580-242-7928. The individual signing this document reserves the right to appeal any decision made regarding assistance provided by Rx for Oklahoma and participating partners. The right to appeal does not guarantee the right to modify individual pharmaceutical company policies and procedures.

_____ _____

Client Signature Date

This program is provided through a joint effort of Community Development Support Association (CDSA), the Oklahoma Department of Commerce and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

Region 1 - Rx for Oklahoma

Located: CDSA
114 S Independence Ave, Enid, OK 73701
Phone: 580-242-7928 Fax: 580-234-3554 Toll Free: 1-877-794-6552

****MUST HAVE COPY OF INSURANCE CARDS & FINANCIAL VERIFICATION TO PROCESS****

Date: _____ Have we assisted you before? Yes No

Client Information:

Name: _____ _____ _____
(First) (MI) (Last)
Street Address: _____
City:_____ State: Oklahoma Zip:_____ County: _____
Phone: (580)_____
SSN: _____-_____-_____ Sex: M / F Date of Birth:_____
Race: _____ Marital Status: _____ Education Level: _____

Household:_____ **Head_____ Spouse_____ Dependent Child_____**
Employment Status: **Full_____ Part_____ Not in Labor Force_____ Retired_____ Unemployed_____**

Number in household: Adults _____ Children _____ **Housing:** Own Rent Stay with Family/Friends
Are you a U.S. Citizen? YES / NO **Are you disabled?** YES / NO **Do you have V.A. benefits?** YES / NO

How did you hear about this program?

Action Agency	Area-wide Aging Agency	Legislative Office	Community Clinic
Flyers	Newspaper	Social Services	Hospital
DHS	Friend/Family	TV/Radio	Employer
Doctor's Office	Health Department	Website/Internet	Other_____

Insurance Information:

PLEASE COPY & ATTACH all insurance cards, front & back. Including Medicare & Medicaid.

☐ Medicare (Medicare #_____) ☐ Medicare Discount Card ☐ Medicaid

☐ Private Health Insurance (Company _____) ☐ None

Do you have prescription insurance? YES NO

Financial Information:

PLEASE Enter your MONTHLY household income from all sources.
i.e. income tax return, SS benefit statement, bank statement, check stubs for entire month
If you currently do NOT have any income, please provided a statement explaining your situation.

Wages:$_____	Unemployment:$_____	Workers Compensation:$_____
SS Retirement:$_____	SS Disability:$_____	Other Disability:$_____
Retirement:$_____	Alimony/Child Support:$_____	Other:$_____
Food Stamps:$_____	TOTAL MONTHLY HOUSEHOLD INCOME: $_____	

Did you file a tax return last year? YES NO Will you file a tax return this year? YES NO

Employment: Do you have a full time job? ___ No ____Yes ___ Not Employed

Education: Have you earned a High School Diploma or a G.E.D.? ___ No ___ Yes

Can you read/write English? ___No ___ Yes

Training: Do you have any skills that can get you a job? ___No ___Yes

Housing: Do you live in affordable, safe housing? ___ No ___Yes

Transportation: Do you have access to a car, public transportation or a regular ride?

___ Always
___ Most of the time
___ No
___ Rarely
___ Sometime

Child Care:

___ I do NOT need Child Care
___ I Need Child Care (If **YES** complete *)
___ I have No Children

***Child Care Enrollment:**

___ My child gets childcare from a family member or friend
___ My child is not enrolled in a child care facility
___ My child is on a waiting list for child care
___ Subsidized
___ Unsubsidized

Eldercare: Do you care for an elderly person? ___ No ___Yes (if **YES** complete [+])

[+]Do you need elder care but can't afford it? ___ No ___ Yes

Health Insurance: Child Health Insurance

___ All have health insurance
___ I have NO children
___ None have health insurance
___ Some have health insurance

Adult Health Insurance

___ All adults have health insurance
___ No adults have health insurance
___ Some adults have health insurance

DHS Programs: Are you currently receiving DHS Services? ___ No ___ Yes (if **YES** complete [#])

[#]List Below:

_____

_____

_____

_____

Primary Physician Information:

Physician Name: _____ Phone:(____)_____

Street Address: _____

City: _____ State: _____ Zip: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP:_____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP: _____

Drug Name: _____ Condition Treated: _____

Strength: _____ Number Taken: _____ Frequency: _____

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _____

Address: _____ Phone: _____

Rx Office Use Only:

PAP:_____

Drug Name: ________________________________ Condition Treated: ____________________________

Strength: ______________ Number Taken: _____ Frequency: _________

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _________________________________

Address: ____________________________________ Phone: _______________

Rx Office Use Only:

PAP:______________________

Drug Name: ________________________________ Condition Treated: ____________________________

Strength: ______________ Number Taken: _____ Frequency: _________

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _________________________________

Address: ____________________________________ Phone: _______________

Rx Office Use Only:

PAP: ______________________

Drug Name: ________________________________ Condition Treated: ____________________________

Strength: ______________ Number Taken: _____ Frequency: _________

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _________________________________

Address: ____________________________________ Phone: _______________

Rx Office Use Only:

PAP: ______________________

Drug Name: ________________________________ Condition Treated: ____________________________

Strength: ______________ Number Taken: _____ Frequency: _________

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _________________________________

Address: ____________________________________ Phone: _______________

Rx Office Use Only:

PAP: ______________________

Drug Name: ________________________________ Condition Treated: ____________________________

Strength: ______________ Number Taken: _____ Frequency: _________

Primary Physician: Yes/No *If **no** please provide:* Physician Name: _________________________________

Address: ____________________________________ Phone: _______________

Rx Office Use Only:

PAP: ______________________

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New Client Questionnaire: Date: _____

1. How did you hear about the Rx for Oklahoma program?
   a. Community Action Agency
   b. Community Clinic
   c. DHS
   d. Doctor's Office
   e. Family/Friend
   f. Flyer/Brochure
   g. Hospital
   h. Presentation
   i. Social Services
   j. TV/Radio
   k. Billboard
   l. Website/Internet Search
   m. Word of Mouth
   n. Newspaper
   o. Other: _____

2. Approximately, how much do you spend monthly on your medications?

   ___$0-$50 ____$51-$100 ____$101-$200 ____$201-$300

   ___$301-$400 ____$401-$500 ____ over $500

3. How have you been getting your medications?

   ____Family/Friend
   ____DHS/SoonerCare
   ____Manufacturer
   ____Pay cash
   ____$4 program at Wal-Mart
   ____Samples from doctor
   ____Free Clinic
   ____Not able to get
   ____Other

4. Age: ____0-20 ____21-40 ____41-64 ____65-80 ____81+

5. Gender: _____Male _____Female

Additional Household Members

Race Legend:

AA	-	Black/African–American	**W**	-	White
H	-	Native Hawaiian/Pacific Is.	**AS**	-	Asian
BM	-	Biracial/Multiracial	**O**	-	Other (refused, don't know etc)
AI	-	American Indian or Alaska Native			

Name		DOB	Gender √		Ethnicity √		Race
First	Last		M			Hisp	

What is the other person(s) yearly income & from what source?

_____

_____

What is your rental or mortgage amount?

_____

This information is required if you are living with another person(s) in the household including relatives, children and non-relatives. This information is for Grant Purposes ONLY; to continue providing this prescription service.

RX FOR OKLAHOMA

Documentation Required

Documentation needed to finish your application. ANYTHING on here that pertains to your situation please provide. Please provide this as soon as possible so there is not a delay in getting medications.

☐	Completed Application	☐	Any Insurance Cards (Copy)
☐	Drivers License (Copy)	☐	Green Card/Residency Information
☐	Wage Information (3 months)	☐	SS Retirement Letter
☐	Retirement	☐	Food Stamp Award Letter
☐	Unemployment Letter	☐	SS Disability Letter
☐	Alimony/Child Support	☐	Workers Compensation
☐	Other Disability	☐	Tax Return Information
☐	Primary Physician Information	☐	Medication List
☐	Patient consent	☐	Public Assistance
☐	Rental/Mortgage Amount	☐	Veteran Information

☐ Any other household member income information (If you are living with another person their income information is required.)

☐ Denial Letter for any type of health coverage applied for

Other_____

_____

Thank you,
Rx for Oklahoma Staff