

Patient Application Packet Checklist:

- Patient Application Form (completed and signed)
- The Pharmaceutical Assistance Contract (completed and signed)
- Patient Medications List (completed)
- One of the following Income Verifications
 - 3 most recent consecutive pay stubs from **ALL MEMBERS** in the household OR
 - 3 most recent consecutive monthly bank statements showing direct wage deposits OR
 - Social Security statement OR
 - Letter explaining your financial situation if you have no income.
- Your family's most recent annual tax return – **this is required if you filed taxes.** (first 2 pages of Form 1040 only). If you didn't file, please disregard.

For help with any of the paperwork mentioned above, please contact
Katherine Carmon, DOC RxRelief Patient Advocate
Email: rxrelief@msv.org

Phone: (804) 377-1005 • Toll free 1-866-796-6691

*****Failure to include any of these materials or incomplete application/contract will cause a delay in the process.**

Checklist for Medicare Part D Patients Have you included?

Your most recent out of pocket expenses from your pharmacy from Jan 1 to current date.

A copy of your Medicare Part D card (front and back).

A copy of the Low Income Subsidy “Extra Help” from Social Security denial letter. (This must come from Social Security and you can obtain this by going to your local Social Security office, calling 1-800-772-1213, or online at www.ssa.gov / complete form SSA-1020. It may take a few weeks for response.)

If you need help or have questions, contact the
Patient Advocate: Katherine Carmon
Email: rxrelief@msv.org Phone: (804) 377-1005 Toll free 1-866-796-6691.

Deadline for Medicare D patients to apply to the program is November 15 each year. This allows time for us to get your paperwork in before the end of the year.

***** Failure to include any of these materials will result in a delay in the application process. *****

DOC RxRelief • Patient Application Form

PERSONAL INFORMATION:

Name: _____ **SSN:** _____
(Last) (First) (MI)

Address: _____
(Street) (City) (ST) (Zip) (County)

Phone: _____
(Home) (Work) (Cell) (Alternate)

Email: _____

Sex: M F **DOB:** ___/___/___ **Marital Status:** _____ **# in household:** ___ (including self)
Alternate contact (spouse/caretaker/friend): _____ **Phone:** _____

INCOME INFORMATION: *Income from ALL MEMBERS of the household must be included.*

Employment: \$ _____ / month **TANF*:** \$ _____ / month
*(Temporary Assistance for Needy Families)

Social Security: \$ _____ / month **Pension:** \$ _____ / month

Disability: \$ _____ / month **Alimony/Child Support:** \$ _____ / month

Unemployment: \$ _____ / month **Other (friend/family help):** \$ _____ / month

TOTAL ASSETS: \$ _____ (savings/checking, IRA, annuities, stocks/bonds/CDs)

MEDICAL INSURANCE INFORMATION:

- 1) Do you have Medicare? Y N
 Do you have Medicare Part D? Y N
 - **If YES,** please see green form of application packet for additional information.
- 2) Are you disabled? Y N / **If YES,** have you been disabled for more than 2 years? Y N
- 3) Are you a US Veteran? Y N
- 4) Do you have medical insurance through Medicaid? Y N
- 5) Have you applied and been denied for Medicaid? Y N
- 6) Check the box that best describes your prescription drug coverage:
 Medicare prescription drug Medicaid Employer Other: _____ None
- 7) Do you receive prescription assistance from any social service agency/clinic? Y N
- 8) Did you file a tax return for this past year? Y N
If YES, you must send a copy of the first 2 pages of form 1040.
- 9) Are you currently enrolled in any of the drug companies' patient assistance programs? Y N

If YES, please list the medication and company:

Medication name	Pharmaceutical Company Name

DOC RxRelief • Patient Application Form

ALLERGIES & HEALTH CONDITIONS:

Allergies:

No known allergy Penicillin Allergy Aspirin Allergy Sulfa Allergy Other: _____

Health Conditions:

Diabetes Epilepsy Heart condition Glaucoma High Blood Pressure

Thyroid Ulcer Other conditions: _____

MEDICATION EXPENSES:

11) How much have you spent on prescription drugs this year (since January)? \$ _____

Please total your receipts or your pharmacy may be able to print out a report for you.

12) How do you pay for your medications? _____

I HEREBY STATE THAT THE INFORMATION ABOVE IS ACCURATE AND I GIVE PERMISSION FOR THE ABOVE INFORMATION TO BE RELEASED TO ANY PHARMACEUTICAL COMPANY WITH REGARDS TO REQUESTS FOR DONATED MEDICATIONS.

Signature of Applicant: _____ Date: _____

Name of Practice: _____

Name of Referring Physician: _____

Physician's Phone: _____



Doctors Optimizing Care

PHARMACY ASSISTANCE CONTRACT

In signing this contract, I agree to the following:

- 1. I understand that I cannot have any prescription coverage while participating in this program, and that I will immediately inform my RxRelief Advocate should my insurance status change.
2. I agree to provide proof of income upon request and will update this documentation annually.
3. I understand that there may be delays in getting my medicine, as it may take 8 - 12 weeks for my medication to arrive from the manufacturer.
4. I agree to promptly notify my RxRelief Advocate and/or Practice upon any changes in my income or the income of those in the household, number of people in the household, contact information, or any changes in my medication.
5. I understand that I will be notified by phone when my medication is delivered to my physician's office. I agree to pick up my medication within five business days, and if I fail to do so my prescription may no longer be available to me.
6. My signature below authorizes the RxRelief Advocate or other agent of the program to sign my name on the necessary forms needed to order my medication. I understand that doing so will expedite the ordering process.
7. I authorize any agent of the program to discuss my medical condition(s) with my provider and to review my medical records to ensure appropriate documentation for application completion.
8. I agree that I will not submit an insurance claim or other claim for payment to any third-party payer for any pharmaceuticals I receive from this program. I agree that any pharmaceuticals that I receive will be used only for my personal use. I agree not to resell, offer for sale, trade or barter, or return for credit any pharmaceuticals.
9. I understand that if my physician is not a participant in the DOC RxRelief program, I will then be responsible for obtaining all the required paperwork for the advocate in order to apply on my behalf.
10. I understand that neither this program nor the agents of it are in any way guaranteeing or promising medication to me.

Patient Signature

Date

Printed Patient Name

Social Security #

Please contact Katherine Carmon, RxRelief Patient Advocate, at (804)-377-1005 or 1-866-796-6691 with any questions regarding this contract.

Patient Medications List

Name: _____ DOB: ____/____/____

Please list all medications you are currently taking. Mark the medications you would like to get assistance with through this program.

See example below.

Need Help	Medication/Drug	Dosage (<i>how much & when do you take it</i>)	Prescribed by (<i>doctor</i>):
<input checked="" type="checkbox"/>	<i>Lipitor 10mg</i>	<i>1 tab once a day</i>	<i>Dr. John Smith</i>
<input type="checkbox"/>			
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Medication Allergies:

Please fill out **all** the information above and **all** other information asked for in this packet to avoid delay in the application process. Thank you.



2924 Emerywood Parkway, Suite 300, Richmond, VA 23294

Katherine Carmon
Prescription Assistance Coordinator
Patient Advocate

I, _____, authorize any agent of the DOC RxRelief program to discuss my medical condition and/or medications and to review my medical records with my provider or anyone concerning my medication.

Patient Signature

Date