PLEASE CONTACT ME AS SOON AS YOU HAVE COMPLETED THE ATTACHED APPLICATION.

THANK YOU!

Kathy Miller

CDSA
Community Solutions

Kathy Miller
Rx for Oklahoma
Program Coordinator
114 S. Independence
Enid OK 73701

580-242-7928
rxok@cdsaok.org
www.cdsaok.org

CDSA
Community Solutions

114 S Independence Ave.
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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
  - ❖ 3 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, veteran's 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 are 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: _____

Client Name Printed): _____

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:** ____-____-_____ **Date of Birth**_____

Gender:
□ Male
□ Female

Pregnant:
□ Yes
□ No

Indicate Your Status
□ Single □ Married □ Widowed
□ Separated □ Divorced □ Child

Ethnicity: □ Hispanic or Latino □ Non-Hispanic or Non-Latino

Race: □ Native American Indian □ Asian □ Caucasian/White □ African American/Black
□ Bi-Racial/Multi-Racial □ Hawaiian Pacific Islander □ Other _____

Primary Language: □ English □ Spanish □ Other _____

Household: □ Head □ Spouse □ Dependent Child

Number in household: Adults ____ Children ____

Housing: □ Own □ Rent □ Stay with Family/Friends

Work Status: □ Employed Full-Time □ Employed Part-Time □ Retired
□ Unemployed < 6 mo. Short Term) □ Unemployed > 6 mo. (Long Term)
□ Unemployed (Not in Labor Force) □ Migrant Seasonal Farm Worker

Citizenship Status: □ American Citizen □ Documented Alien □ Undocumented Alien □ Unknown

Served in Military: □ No □ Yes, Active □ Yes, Veteran

Disabled: □ Yes □ No □ Other:_____

Food Stamps: □ Yes $_____ □ No **WIC:** □ Yes □ No

Disconnected Youth: □ No □ In school//Not working □ Not In School / Working □ Not In School / Not Working

Check Highest Grade Completed: □ 0-8th grade □ 9-12th grade □ High School Graduate □ GED □ 12+ some secondary school □ 2-year college graduate □ 4-year college graduate □ Child (under age 18)

I am experiencing the following stressors.....(check all that apply):

□ Transportation □ Housing (homeless, late on rent, safety issues)
□ Lack of Social Supports (few family or friends) □ Relationship Trouble
□ In Recovery from Alcohol/Drug Use □ Employment
□ Physical Health □ Mental Health (current or past) □ Other:_____

Health Insurance: □ Medicare □ Medicaid □ Military Health Care □ State Health Insurance For Adults □ State Children's Health Insurance □ Employment Based □ Direct Purchase □ None

Do you have prescription insurance? □ YES □ NO

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

Non-Cash Benefits: □ None □ Affordable Care Act Subsidy □ Childcare Voucher □ Housing Choice Voucher □ HUD-VASH □ LIHEA □ Permanent Supportive Housing □ Other:_____

PLEASE Enter your MONTHLY household income from all sources.
income tax return, SS benefit statement, bank statement, check stubs for entire month

Employment: $_____ Unemployment: $_____Workers Compensation: $_____
SS Retirement: $_____SS Disability: $_____ Veteran's Benefits $_____
Retirement/Pension: $_____TANF $_____ Alimony/Child Support: $_____ Other: $_____
Interest Dividends $_____ *TOTAL MONTHLY INCOME $*_____
*(Do **not** include income from other members of household listed on additional form.)*

□ **No Income**
If you currently do NOT have any income, please provide a statement explaining your situation on the DECLARATION OF NO INCOME form provided.

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

Please complete this side of the form for the additional members of your household.

SSN	First Name	Last Name	Date of Birth	Male or Female	(Y) or (N) Pregnant	Using the key below please answer the following: Marital Status	Relation to Applicant	Ethnicity	Race	Education (age 18+)	Health	Disconnected Youth	Non-Cash Benefits	Work Status	$$$ Monthly Income	Use Table Below Source of Income

Marital Status
A. Single
B. Married
C. Widowed
D. Separated
E. Divorced
F. Child

Relation to Applicant
A. Mother
B. Father
C. Child
D. Sister
E. Brother
F. Guardian
G. Partner
H. Friend
I. Spouse
J. Grandparent
K. Foster Parent
L. Foster Child
M. Grandchild
N. Other:_____

Ethnicity
A. Hispanic or Latino
B. Non-Hispanic or Non-Latino

Race
A. Native American
B. Asian
C. Caucasian/White
D. African-American/Black
E. Bi-Racial/Multi-Racial
F. Hawaiian/Pacific Islander
G. Other:_____

Education
If household member is over age 18, indicate highest grade completed.
A. 0-8th grade
B. 9-12th grade
C. High School Graduate
D. GED
E. 12+ some secondary school
F. 2-year College Graduate
G. 4-year College Graduate
H. N/C Child under age of 18

Health Insurance
A. Direct Purchase
B. Employment-Based
C. Indian Health Services
D. Medicaid
E. Medicare
F. Military Health Care
G. State Insurance (SoonerCare)
H. State Insurance for Adults

Disconnected Youth
A. In-school/Not Working
B. Not Working/Not in School
C. Working/In-School
D. Working/Not in School
E. Unknown

Non-Cash Benefits
A. SNAP (Food Stamps)
B. WIC
C. Affordable Care Act Subsidy
D. Childcare Voucher
E. HUD-VASH
F. Indian Commodities
G. LIHEAP
H. None
I: Other:_____

Work Status
A. Serves in the Military-Current
B. Has Served in the Military
C. Employed Full Time
D. Employed Part-Time
E. Migrant Seasonal Worker (Farmer)
F. Retired
G. Unemployed (Long Term) > 6 mo.
H. Unemployed (Short Term) < 6 mo.
I. Unemployed (Not in Labor Force)
J. Disabled and Not Employed

Source of Income
Please indicate your source(s) of income.
A. Employment Only
B. Employment + Other sources _____
C. Social Security
D. SSDI
E. SSI
F. Child Support
G. TANF
H. Interest Dividends
I. Unemployment Insurance
J. Pension
K. Worker's Comp
L. Veteran's Benefits
M. No Income
N. Other:_____

Primary Physician Information:

Physician Name: ______________________________ **Phone:**(____) __________

Street Address: ______________________________

City: __________ **State:** _____ **Zip:** ________ **Allergies:** ______________________________

Drug Name: ______________________________ Condition Treated: ______________________________

Strength: ____________ Number Taken: _____ Frequency: ________ Price you pay: ____________

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: ________ Price you pay: ____________

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: ________ Price you pay: ____________

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: ________ Price you pay: ____________

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: ________ Price you pay:__________

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: ________ Price you pay:__________

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: ________ Price you pay:__________

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: ________ Price you pay:__________

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

Address: ______________________ Phone: __________

Rx Office Use Only:

PAP: __________

CDSA
Community Solutions

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Enid, OK 73701
580-242-7928 Fax 580-234-3554
www.cdsaok.org

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

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

Rx for Oklahoma
Community Development Support Association
114 S Independence Ave
Enid, OK 73701
(580) 242-7928
Toll Free: 1-877 RX4-OKLA (794-6552)

Self-Declaration of Income

I, _____,

☐ declare that I have been working and receive cash payments in the amount of $_____.
I do not have check stubs or other proof of income.

☐ declare that I do not have any income at this time.

If you do not have an income, please explain your circumstance.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

As an advocate for the Rx for Oklahoma program, I verify that this client has no verifiable income at this time.

_____ _____

Signature Date