RPMH
Prescription Assistance Program

200 E Arizona Ave (PO Box 690)
Sweetwater, TX 79556

Phone (325) 235-6824 Fax: (325) 219-6045

Date: _____

Dear Client: _____

Thank you for your interest in receiving assistance through Rolling Plains Memorial Hospital Prescription Assistance Program (RPMH PAP). **To begin eligibility you must have a physician in Nolan County or live in Nolan County.** You must complete the application packet and return it to the office with the following information for eligibility determination before medications can be ordered on your behalf:

- ☐ Copy of social Security Card
- ☐ Copy of Driver's License or State ID Card
- ☐ Copy of utility bill with current address.
- ☐ Health insurance information. Copy of Ins. Card (including Medicare, Medicaid and Medicare-Part D Drug Plan, Medicare supplement). If you have been denied by Medicaid, please include a copy of the denial letter.
- ☐ Please provide a printout of medication purchases from your pharmacy beginning January 1, to present.
- ☐ If you are enrolled in **Medicare Part D**, provide a copy of the current EOB monthly statement from Medicare. Some pharmaceutical companies will not assist you until you have spent $600 out of pocket on prescription expenses since January 1st of the current calendar year.
- ☐ Copy of current Social Security Benefit Statement (Award Letter), VA Benefits, Retirement Benefits, Pension and bank statement showing Direct Deposit (must be for current year but no more than 1(one) month old. Documentation for all members of the household must be included.
- ☐ Copies of check stubs for salary/wages, unemployment, child support, alimony, and food stamps (must be current for year but no more than 1 month old). Documentation for all members of the household must be included.
- ☐ Tax forms must be current within one year. (Appropriate schedules must be included).
- ☐ IRS Form 4506, Verification of Non-filing must be completed, if not required to file income tax.
- ☐ List all medications and dosages you are currently taking. Please include supplements, over the counter medications, vitamins, etc. (Remember, it is your responsibility to re-order medication 30 days before you run out).

When your completed application is received with all necessary documentation, we will determine eligibility within 10 days. If you are eligible, we will send a letter of eligibility to notify you and request that you make an appointment to sign forms for the pharmaceutical companies.

We will send all pharmaceutical requests to your Primary Care Physician for approval and prescriptions. It will take approximately 1 week for the physician to return the paperwork to our office.

We will then complete the application process and mail request(s) to the pharmaceutical company. It will take approximately 4 weeks from the time we mail the request to receive medication. Some pharmaceutical companies take longer (up to 6-8 weeks) to ship medications the first time.

If you have any questions or require further assistance, please contact us at (325) 235-6824 between the hours of 9:00 am and 2:00 pm, Tuesday through Thursday (excluding holidays).

Sincerely,

Debbie McIntire

Case Manager

RPMH
PRESCRIPTION ASSISTANCE PROGRAM
APPLICATION FOR ASSISTANCE

Client Name:_____ **Date:**_____
First MI Last

Address:_____

Phone #: _____ **Phone # Other :** _____

Social Security #: ____/____/_____ **Date of Birth:** _____/_____/_____

Gender: M F # of adults _____ # of children in home _____ Marital Status: S M W D

		(circle one)	
US Resident	Y N	**Disabled**	Y N
Veteran	Y N	**If yes, have you been disabled more than 2 years?**	Y N

Total Gross MONTHLY Household Income:

Include income of all persons who contribute to or are dependent on patient's household income.

Salary/Wages_____ **Social Security Dis.**_____ **Soc. Sec. Retire**_____ **Pension/Retire.**_____
Vet. Benefits _____ **SSI** _____ **Workers Comp**_____ **Unemp**_____
Alimony/Ch. Sup_____**Rental Income** _____ **Other**_____

Insurance Information: Indicate if pt has RX benefits or medical benefits through any of the following insurers/payers/programs.

Insurer/Payer/Program	RX Benefits (circle)	Medical Benefits	Insurer/Payer/Program	RX Benefits (circle)	Medical Benefits
Medicare A&B	Y N	Y N	**Medicaid**	Y N	Y N
Medicare Supplemental Plan	Y N	Y N	**Private Insurance**	Y N	Y N
List Insurer if "Y"			List Insurer if "Y"		
Medicare Part D (Drug Coverage	Y N	Y N	**VA Medical Benefits**	Y N	Y N
List Insurer if "Y"					
None-Uninsured	Check if applicable	☐	Attach copy (front and back) of RX drug card and health insurance card if patient is insured. Including Medicare and Medicaid.		

Allergies: (circle all that apply) None Penicillin Codeine Sulfa Aspirin
Other Allergies: _____

Name of your Primary Physician: _____
Address: _____**Phone #** _____

Total Value of Household Assets:

Include all persons who contribute to or are dependent on patient's household income.

Stocks/Bonds_____ **Checking/Savings**_____ **IRA**_____ **Annuities**_____
CDs_____ **Other** (Please Specify) _____

Own your Home	Y N	**Live with Family /Friends**	Y N
Rent	Y N	**Food Stamps**	Y N

Medications you want RPMH PAP to order for you? (5 medications if you do not have RX insurance, 2 medications if you are insured or have Medicaid).

	MEDICATION	DOSAGE	How many times per day?	Why did Dr. Prescribe this medication?
1				
2				
3				
4				
5				

Other Medications you are taking:

	MEDICATION	DOSAGE	How many times per day?	Why did Dr. Prescribe this medication?
1				
2				
3				
4				
5				

Notes:

_____

_____

_____

_____

I have read, understand and accept the information on this form relating to the RPMH Prescription Assistance Program (Program) including the limitations and authorization to use and disclose information attached to this form. I certify that the information I have provided in this application is accurate and complete. I certify that I do not have drug coverage through any insurance, employer, government program or any other source to cover the medication(s) requested.

By signing below, I agree to the terms and conditions of the Program.

_____ _____
Signature of Applicant Date

RPMH
PRESCRIPTION ASSISTANCE PROGRAM

AUTHORIZATION TO SHARE HEALTH INFORMATION FOR REIMBURSEMENT OR PATIENT ASSISTANCE PROGRAMS.

Client Name: _____ DOB: _____

Client Address: _____

City: _____ State:_____ Zip Code:_____

I, _____, authorize the Prescription Assistance Program, my doctor(s), any other health care providers, and my health plan or insurers to give medical information relating to my use or need for pharmaceutical products.

This information can include spoken or written facts about my health and payment benefits that I may have. It can include copies of records from my health care providers or health plans about my health or health care.

The Prescription Assistance Program will use and give out this information to see if I qualify for the various pharmaceutical companies medication assistance programs. People who work for and with the Prescription Assistance Program and various pharmaceutical programs may also see my information, but they may use it only to help me get assistance with the costs of my drugs. I understand that they will make every effort to keep my information private. I also understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules and therefore federal privacy laws will not protect it.

This authorization will last until I am no longer participating in the Program. If I change my mind before that time, I can tell my healthcare provider and my insurers in writing that I do not want them to share any more information with the Prescription Assistance Program but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my health care providers or insurers have given to the Rolling Plains Memorial Hospital Prescription Assistance Program. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

Client Sign Here: _____ Date:_____

Client Name: _____

If the patient cannot sign, client's personal representative must sign below:

Print Client Name: _____

By: _____
(Signature of person signing for the client)

Print Representative Name: _____
Relationship to the client: _____
Authority to make medical decisions for the client: _____
_____

RPMH
PRESCRIPTION ASSISTANCE PROGRAM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of the Rolling Plains Memorial Hospital Prescription Assistance Program's Notice of Privacy Practices that describes how my protected health information is used and shared. I understand that the Rolling Plains Memorial Hospital Prescription Assistance Program has the right to change this notice at any time. I may obtain a copy by contacting the program.

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the Rolling Plains Memorial Hospital Prescription Assistance Program.

_____ _____
Name of client (please print) Date

_____ _____
Signature of client or representative Relationship to the client

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

The Acknowledgement of Receipt of Notice of Privacy was mailed to the patient for signature because

_____ The patient was a minor and the Notice of Privacy Practices and Acknowledgement were mailed to the parent/legal guardian.

_____ The patient is home bound and unable to physically get to the Prescription Assistance Office.

_____ The patient declined to sign the Acknowledgement.

_____ Other_____

Name of Patient _____

Name of Staff Member _____

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

The Rolling Plains Memorial Hospital Prescription Assistance Program is required by law to provide the attached Notice of Privacy Practices. The notice includes the following elements in greater detail.

Uses and disclosures

- A description of the types of uses and disclosures that the Rolling Plains Memorial Hospital Prescription Assistance Program is permitted to make for treatment, payment and healthcare operations.
- A description of other purposes for use and disclosure which do not require the patient's authorization, which may be revoked by the patient.

Individual Rights

- The patient's rights include:
- The right to receive confidential communications.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an account of disclosures.
- The right to receive a printed copy of the Notice of Privacy Practices.

Rolling Plains Memorial Hospital Prescription Assistance Program Responsibilities

We are required by law to:

- Make sure that protected health information that identifies you is kept private.
- Give you this notice of our legal duties and responsibilities and privacy practices with respect to protected health information.
- Follow the terms of the notice that is currently in effect.

Revision of Privacy Practices

- We reserve the right to modify the Notice of Privacy Practices for all protected health information we maintain.

Complaints

If you feel your privacy rights have been violated you may:

- Complain to the Privacy Officer at Rolling Plains Memorial Hospital, or
- Complain to the Secretary of Health and Human Services

If you file a complaint, you will not be penalized or retaliated against.

Further information
For further information or to ask questions about this Notice of Privacy Practices, contact the Privacy Officer of Rolling Plains Memorial Hospital.

The effective date of this Notice is November 26, 2003

We will not use or disclose your health information without your written authorization, except as described in this notice. You may revoke your authorization by presenting your written revocation to the Rolling Plains Memorial Hospital Prescription Assistance Program.

For More Information or to report a Problem:
If you have additional questions and would like additional information, you may contact the Privacy Officer (325) 235-1701.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Advocacy:

- We will use your personal information and medical information to assist in obtaining medications from the various pharmaceutical programs.
- We will disclose personal information to the physician's offices to obtain prescriptions and various assistance from these healthcare providers.
- We will use your health information for regular operations. This would include such things as reviewing records to assess the care and outcomes for quality improvement purposes.
- We will disclose personal and medical information to an appointed local pharmacy to assist you in obtaining medications received from the various pharmaceutical programs.