Rx for Oklahoma
P.O. Box 603
Jay, OK 74346
Phone: 918-253-4683 ext 34 or 29
Fax: 918-253-6059
Email: lindaely@neocaa.org
Email: lrutherford@neocaa.org

Serving Craig, Delaware and Ottawa Counties

Thank you for your interest in the Rx for Oklahoma Prescription Assistance Program.

Please complete and sign the attached 4 page application. Be sure to include all of the medications you are taking, the strength, and dosage.

The pharmaceutical companies require proof of your income. In order to process your application timely, please provide a copy of the following documents for ALL members of your household:

1. *Most recent tax return, if you filed*
2. *Social Security determination letter for the current year if you receive Social Security or Social Security Disability*
3. *Copy of pay-stubs for the past 30 days if you are working*
4. *Documentation of any other income such as unemployment compensation, child support, alimony or food stamps*
5. *Copy of your Picture ID or Drivers License*

Send the completed 4 page application and above documents to Linda Ely, Rx for Oklahoma, PO Box 603, Jay, OK 74346.

If you have questions, please contact the program by phone or email listed above.

NORTHEAST OKLAHOMA COMMUNITY ACTION AGENCY
APPLICATION FOR SERVICES

APPLICATION DATE: _____

APPLICANT'S NAME: _____
LAST FIRST MIDDE INITIAL

MAILING ADDRESS: _____

APPLICANT'S ADDRESS: _____
CITY STATE ZIP COUNTY

PHONE NUMBER: _____

SIZE OF FAMILY: _____

DO YOU OWN_____ RENT_____ or HOMELESS_____

ANYONE IN YOUR HOME DISABLED OR HANDICAPPED?_____ IF SO, WHO:_____

ANYONE IN YOUR HOME A VETERAN?_____ IF SO, WHO: _____

ANYONE IN YOUR HOME RECEIVE FOOD STAMPS?_____ IF SO, WHO:_____

ANYONE IN YOUR HOME RECEIVE WIC? _____ IF SO, WHO:_____

INFORMATION ABOUT FAMILY MEMBERS (INCLUDING APPLICANT):

NAME	Date of Birth	Social Security Number	Relationship to Applicant	Ethnicity	Race	Education	Gender	Marital Status	Health Ins?
(Please choose the correct response from the available choices for each family member)			Spouse Child Grandchild Other	Hispanic Non-Hispanic	White Black Amer Indian Asian Bi-Racial Other	0-8 grade 9-12 Non-grad HS Grad HS+Some college 2-4 yr college	Male Female	Child Single Married Separated Divorced Widowed	Yes No

CURRENT SOURCES OF INCOME AND AMOUNT:
WAGES:

Family Member	Job 1	How Often?	Amount	Job 2	How Often?	Amount	Job 3	How Often?	Amount

OTHER SOURCES OF INCOME:

	Family Member	How Often?	Amount	Family Member	How Often?	Amount
Social Security						
Pension						
Unemployment						
General Assistance						
SSI						
Child Support						
TANF						
Other						

SERVICES NEEDED: EMERGENCY ASSISTANCE _____ HEAD START_____ PRESCRIPTION ASSISTANCE_____ TAX PREPARATION_____
HOME WEATHERIZATION _____ HOME BUYER EDUC_____ HOME OWNERSHIP _____ HOME REHABILITATION_____

PLEASE DESCRIBE YOUR CURRENT SITUATION AND THE REASON FOR YOUR APPLICATION:

_____

_____

I understand this Agency may need to share this information with other agencies and/or organization to best service my needs. Northeast Oklahoma Community Action Agency and the Salvation Army and their representatives have my consent and permission to share this information with other agencies and/or organizations. I have read this agreement and understand it. I voluntarily sign my consent
I understand I have the right to appeal decision of agency personnel. I understand that a copy of the policy is available to me upon request.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

Program Eligibility Questions

Even if you have come to the agency to request a specific service, you may be eligible for more than one service that the agency provides. Please take the time to answer these questions to help us determine what services you might qualify for and those that you may be interested in receiving.

Head Start	***Yes***	***No***
Was a child in your family 3 or 4 years old by September 1 of the current year or will you have a child who will be 3 or 4 years old by next September?		
Even if you may not be financially eligible for service, your child may be eligible if your family is homeless, if any member of your family receives Social Security Income (SSI), Temporary Assistance to Needy Families (TANF), or if the child is a foster child. Do any of these describe your family?		

Early Head Start	***Yes***	***No***
Is any child in your family between the age of birth and three?		
Is there a pregnant woman in your household?		
Are you within driving distance of Jay?		
Even if you may not be financially eligible for service, your child may be eligible if your family is homeless, if any member of your family receives Social Security Income (SSI), Temporary Assistance to Needy Families (TANF), or if the child is a foster child. Do any of these describe your family?		

Emergency Assistance	***Yes***	***No***
Do you have an unexpected emergency and can't pay a past due utility bill?		
Do you have an unexpected emergency and can't pay a past due rent or mortgage payment?		
Do you have an unexpected emergency and can't purchase a short-term medication?		

Home Ownership	***Yes***	***No***
Do you plan on purchasing a home in the next year?		
If you are interested in purchasing a home in the next year, have you owned a home anytime during the last three (3) years?		

Housing Rehabilitation	***Yes***	***No***
Do you own your home?		
If you own your home, have you owned the home for at least one year?		
Does your home need repairs of more than $1000?		
Is this home your primary residence?		
Is the deed to your home in your name?		

Weatherization	***Yes***	***No***
Does your home have high energy bills and are you interested in weatherizing your home?		

Housing Rental	***Yes***	***No***
Are you currently looking for rental housing?		

Prescription Assistance	***Yes***	***No***
Do you have ongoing medication needs?		
Do you have prescription insurance that helps to pay for your medication?		
Are you or is someone in your family in the "Medicare donut hole"?		

Sooner Care and SNAP (Food Stamps)	***Yes***	***No***
Is there a child in your household younger than 19?		
Is there a pregnant woman in your household?		
Are you a US citizen or qualified alien?		
Are you an Oklahoma resident?		
Is a member of your family receiving TANF benefits and has a child living in the home?		

Please answer the following questions:

U.S. Citizen: ☐ Yes ☐ No

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐Retired

If you are employed please list employer: _____
Continued:

Are you Legally Disabled: ☐ Yes ☐ No If so how long?
_____

Do you have any allergies? ☐ Yes ☐ No If yes please list:
_____

Insurance Information: Please copy and attach all insurance cards front and back including Medicare and Medicaid cards. If you have received a Medicaid denial letter, also include a copy.

Do you have: (Please check all that apply)

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

☐ Private Health Insurance (Company :_____) ☐ No Insurance

☐ Prescription Insurance including Part D Medicare

Did you file a tax return last year? ☐ Yes ☐ No

Will you file a tax return this year? ☐ Yes ☐ No

PRIMARY PHYSICIAN INFORMATION:

PHYSICIAN NAME_____**PHONE NUMBER**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

Please list ALL prescriptions. If medication was prescribed by a different physician than the one listed above, check "NO" and complete the new physician information.

PRESCRIPTION 1 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

RELEASE 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 manufactures to offer assistance and provided medications to low-income and 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 to complete 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 includes signing your name on your behalf. This authorization may be revoked at any time by contacting the Prescription Assistance Service, Rx for Oklahoma at 918-253-4683 ext. 34 or 29. 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 Northeast Oklahoma Community Action Agency and the Oklahoma Department of Commerce, and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

Please list ALL prescriptions. If medication was prescribed by a different physician than the one listed above, check "NO" and complete the new physician information.

PRESCRIPTION 1 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

PRESCRIPTION 2 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

PRESCRIPTION 3 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

PRESCRIPTION 4 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

PRESCRIPTION 5 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____

PRESCRIPTION 6 **PRIMARY PHYSICIAN?** ☐ **YES** ☐ **NO**

Name of Medication_____**Strength**_____**Dosage**_____

PHYSICIAN NAME_____**PHONE #**_____

ADDRESS_____**CITY**_____**ZIP**_____