PRESCRIPTION ASSISTANCE

Rx for Oklahoma
P.O. Box 603
Jay, OK 74346
Phone: 918-253-4683 ext 163
Fax: 918-253-6059
Email: ctempleman@neocaa.org
Email: tlockhart@neocaa.org

Serving: Adair, Cherokee, Craig, Delaware and Ottawa Counties

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

Please complete and sign the attached application. Please be sure to include all of the medication you are taking, the strength, dosage and the health condition for which the medication is prescribed.

The pharmaceutical companies require proof of your household income. They will not accept "Zero" as proof of income. Please provide a copy of the following documents for ALL members of your household:

1. **Most recent tax return if you filed. If you are required to file and did not, you must sign an IRS form 4506T form, or**

2. **Social Security determination letter for the current year if you are receiving Social Security, Social Security Disability or Social Security Supplemental Income, or**

3. **Copy of pay-stubs for the past three pay periods if you are working, or**

4. **Documentation of any other income such as unemployment compensation, child support, alimony or any source of household income**

Additional items needed:

1. **Copy of driver's license or picture ID**
2. **Copy of Medicare, Medicaid or insurance card (front and back)**

Please send the completed application and other documents to Cindy Templeman at the above address.

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AMERICA'S POVERTY FIGHTING NETWORK

PRIMARY APPLICATION

NORTHEAST OKLAHOMA COMMUNITY ACTION AGENCY

Application for Services

EACH QUESTION MUST BE ANSWERED COMPLETELY TO BE CONSIDERED FOR ANY OF OUR SERVICES

in Household: _____ Todays Date: _____

Head of Household (Applicant): _____
Last First Middle

Physical Address _____
Street CITY COUNTY ZIP

Mailing Address _____
Street CITY COUNTY ZIP

1ST PHONE: _____ **2ND OR MSG PHONE:** _____

Are you the custodial or legal Guardian of minor children in household? _____ Child Name(s): _____

Has **Child Support** been ordered by the court? Yes or No: _____ If Yes, Do you receive Child Support? _____

DO YOU OWN OR RENT?	**MOVE IN DATE?**

HOMELESS SITUATION:

ARE YOU NATURAL DISASTER EVACUEE? YES _____ NO _____

ARE YOU CURRENTLY HOMELESS? YES _____ NO _____

HOW LONG? _____

IF YES, WHERE HAVE YOU BEEN STAYING? _____

INCLUDING THIS TIME, HOW MANY TIMES IN THE PAST THREE YEARS HAVE YOU BEEN HOMELESS? _____

TOTAL COMBINED # OF MONTHS IN THE PAST 3 YEARS?

DOMESTIC VIOLENCE SITUATION:

Are you currently or have you ever been in a domestic violence situation? YES _____ NO _____

If yes, how long ago? _____

Are you currently fleeing? YES NO

Please describe your situation and the reason you are requesting assistance: _____

Applicant has the right to appeal decision of agency personnel. You may obtain a copy of the policy from any staff member. 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 organizations. I have read and understand this agreement and understand a copy of the policy is available to me upon request.

_____ _____

Signature of Applicant ***Date***

LIST ALL INCOME FOR EACH FAMILY MEMBER (IF NONE IN EACH OF THESE CATAGEGORIS, PUT "O")

EMPLOYER OR SELF EMPLOYED? **Supervisor:** **Phone Number:**

FAMILY MEMBER	COMPANY NAME	DATE HIRED	HRS WEEKLY	HOURLY WAGE	HOW OFTEN PAID	GROSS AMOUNT	LAST 30 DAYS INCOME

SOURCES OF INCOME IN LAST 30 DAYS: WAGES, SS, SSI, SSDI, CHILD SUPPORT, PENSION, TANF, UNEMPLOYMENT, ETC

Family Member Name	TYPE OF INCOME	Amount	Family Member Name	TYPE OF INCOME	Amount
	S.S. Retirement			SSI	
	SSDI Disability			SSI	
	SSI			SSI	
	Pension			Pension	
	Child Support			Child Support	
	TANF			TANF	
	Workers Comp			Workers Comp	
	Unemployment Ins.			Unemployment Ins.	
	VA Compensation			VA Compensation	
	VA Pension			VA Pension	
	Rental income			Rental income	
	Interest/Dividends			Interest/Dividends	
	Other			Other	
	None			None	

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NORTHEAST OKLAHOMA COMMUNITY ACTION AGENCY

JAY, OK

Application for Services

EACH QUESTION MUST BE ANSWERED COMPLETELY TO BE CONSIDERED FOR ANY OF OUR SERVICES

Head of Household (Applicant): _____ Today's Date: _____ How did you hear about our service? _____

NAME (Start with Applicant first)	Date of Birth	Social Security Number	Relation to Applicant	Ethnicity	Race	Education	Gender	Marital Status	Health Ins?	Disabled	Military Status	YOUTH 14-24 years of age	Work Status	Non-Cash Benefits
(Please choose the correct response from the available choices for each family member)	[redacted]	[redacted]	Spouse	Hispanic	White	0-8 grade	Male	Child	1. None	answer yes or no for each family member	1.Veteran	1.not working-not in school	1.Employed-Full time	1. SNAP
			Child	or	Black	8+Non-grad	Female	Single	2. Medicaid		2.Active	2.working-not in school	2.Employed-Part time	2. WIC
			Grandchild	Non-Hispanic	Am Indian	HS Grad	Unspecified	Married	3.Medicare		3.Unknown/not reported	3.in school-not working	3.Retired	3. LIHEAP
			Parent		Asian	Some col	Other	Separated	4. Employer		4.NO Military status		4.Disabled	4. Housing voucher
			Non-related		Bi-Racial	2-4 yr col		Divorced	5.Military				5.Unemployed-6 mos or less	5. Public Housing
									6. Direct Purchase				6.Unemployed-more than 6 mos	6.Permanent Support Housing
START BELOW									7.Sooner Care				7.Unemployed	7. Childcare Voucher
START BELOW WITH APPLICANT FIRST				If American Indian					8.Unknown/ not reported				8.Unknown/not reported	8. Affordable Care Act
				CDIB #					9.Indian Health					9. not eligible 10. not applied 11 no need
COMPLETE EACH SECTION FOR EACH FAMILY MEMBER				COMPLETE EACH SECTION FOR EACH FAMILY MEMBER						COMPLETE EACH SECTION FOR EACH FAMILY MEMBER				
			APPLICANT											

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: _____

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

_____

Are you allergic to any medications ☐ 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 If yes, please provide a copy

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

Have you purchased any coverage through the Marketplace Health Exchange ☐ 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 HEALTH CONDITION:_____

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

PHYSICIAN NAME_____ **PHONE #**_____

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

PRESCRIPTION 2 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

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

PHYSICIAN NAME_____ **PHONE #**_____

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

PRESCRIPTION 3 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

Name of Medication _____ Strength _____ Dosage _____

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

PRESCRIPTION 4 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

Name of Medication _____ Strength _____ Dosage _____

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

PRESCRIPTION 5 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

Name of Medication _____ Strength _____ Dosage _____

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

PRESCRIPTION 6 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

Name of Medication _____ Strength _____ Dosage _____

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

PRESCRIPTION 7 PRIMARY PHYSICIAN? ☐ YES ☐ NO HEALTH CONDITION: _____

Name of Medication _____ Strength _____ Dosage _____

PHYSICIAN NAME _____ PHONE # _____

ADDRESS _____ CITY _____ ZIP _____

If you have more than seven medications please use the back of the page. Be sure to put all the information needed for each medication. If you have any questions please contact an RX Client Advocate, at 918-253-4683 ext. 163 or 129.

CONFIDENTIALITY AND 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 provide 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.

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. 163 or 129. 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.

Rx for Oklahoma employees respect and will protect every client's right to have all information they share with the agency employees to be kept confidential in a locked file cabinet. In terms of confidential information, such information will not be released to anyone without written permission of the individuals involved and/or the agency.

_____ _____

Client Signature Date

SS#_____ DOB_____

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.

NORTHEAST OKLAHOMA COMMUNITY ACTION AGENCY

CLIENT SURVEY

Please help us to serve you better by completing the survey, thank you *Date*_____

1. From what programs did you receive assistance?

___Emergency Assistance – Rent/Utility Service/Homeless Assistance/Deposit

___RX of Oklahoma (Prescription Assistance)

___Financial/SSI/ Employment Skills

___Housing Weatherization

___Housing Rehabilitation

___Agency Rental Housing

___Free Tax Preparation

___Early Head Start/Daycare Services

___TANF Literacy

___Other _____

2. Were you satisfied with the outcome of your visit? **YES or NO**
3. Will the service you received improve you/your family's stability? **YES or NO (lower energy cost, on going medication needs, employment, gain/maintain housing)**
4. Will the service you received from the agency, assist you/your family's immediate need? **YES or NO? (Utility disconnection ,eviction, ect.)**
5. How did you find out about us? _____.
6. Was the person that assisted you friendly? **YES or NO**
7. Do you feel like you were treated with respect? **YES or NO**
8. Did the person you met with inform you of other services our agency offers? **YES or NO**
9. Do you feel that your need was met in a timely manner? **YES or NO**
10. **Please add any additional comments that you feel would help us to serve you better.**

_____

_____

_____

_____

This agency continues to offer new programs. Would you like to stay informed & receive our monthly newsletter___ YES or___ NO if yes, please supply us with your email address:

_____@_____

Program Eligibility Questions

CLIENT NAME: _____

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.

Head Start / Early Head Start / Day Care Services	**Yes**	**No**
Is anyone in the household in need of Day Care for their children?		
Is any child in your family between the age of birth and three?		
Is there a pregnant woman in your household?		
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		
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		

Emergency Assistance	**Yes**	**No**
Are you currently homeless?		
Do you have an unexpected emergency and can't pay a past due utility bill? *If yes, please circle service(s) needed* *Electric* *Natural Gas* *Propane* *Water*		
Do you have an unexpected emergency and can't pay a past due rent or mortgage payment?		

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

Home 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?		

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

Prescription Assistance	**Yes**	**No**
Do you have short-term emergency OR 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?		
Is a member of your family receiving TANF benefits and has a child living in the home?		

Financial / SSI Assistance / Job Training / Job Skills / TANF Literacy	**Yes**	**No**
Is anyone in the home currently looking for employment?		
Does anyone in the home need job skills refreshed or training?		
Does anyone in the home need assistance applying for SSI or SSDI benefits?		

Free Tax Preparation / Filing Services	**Yes**	**No**
Does anyone in the home need to file their taxes?		

Other Services from this Agency the client is interested in *(please fill in below):*	**Yes**	**No**