C.A.R.D., Inc.
Sheri Simmons
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Broken Arrow, OK 74012
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Serving Tulsa County

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 for.

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 file. If you are required to file and did not, you must sign an IRS form 4506T form,
2. Social Security determination letter for the current year if you are receiving SS, SSI, or SSID
3. Copy of paystubs for the past three months is available
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 completed and signed application and other document Sherri Simmons to to the address above

EQUAL HOUSING OPPORTUNITY

Helping People. Changing Lives.
community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

PRIMARY APPLICATION

Northeast Oklahoma Community Action Agency, Inc.

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 CATEGORIES, "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	

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)			**1**. Spouse	**1**. Hispanic	**1**. White	**1**. 0-8 grade	**1**. Male	**1**. Child	**1**. None	answer	**1**. Veteran	**1**.not working-not in school	**1**.Employed-Full time	**1**. SNAP
			2. Child	or	**2**. Black	**2**. 8+Non-grad	**2**. Female	**2**. Single	**2**. Medicaid	yes or no	**2**. Active	**2**.working-not in school	**2**.Employed-Part time	**2**. WIC
			3. Grandchild	**2**. Non-Hispanic	**3**. Am Indian	**3**. HS Grad	**3**. Unspecified	**3**. Married	**3**.Medicare	for each	**3**. Unknown/not reported	**3**.in school-not working	**3**.Retired	**3**. LIHEAP
			4. Parent		**4**. Asian	**4**. Some col	**4**. Other	**4**. Separated	**4**. Employer	family member	**4**. NO Military status		**4**.Disabled (SSA)	**4**. Housing voucher
			5. Non-related		**5**. Bi-Racial	**5**. 2-4 yr col		**5**. Divorced	**5**.Military				**5**.Unemployed-6 mos or less	**5**. Public Housing
			6. Sibling			**6**. GED		**6**. Widowed	**6**. Direct Purchase				**6**.Unemployed-more than 6 mos	**6**.Permanent Support Housing
									7.Sooner Care				**7**.Unemployed	**7**. Childcare Subsidary: DHS or Tribal?
									8.Unknown/ not reported				**8**.Unknown/not reported	**8**. Affordable Care Act
									9.Indian Health					**9**. not eligible 10. not applied 11 no need

CHOOSE FROM THE CORRECT ANSWERS ABOVE

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
1			APPLICANT											
2														
3														
4														
5														
6														
7														
8														
9														
10														

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.

RX OF OKLAHOMA

PRESCRIPTION ASSISTANCE CLIENT CONTRACT

READ THIS FORM IN ITS ENTIRETY BEFORE SIGNING

The Rx for Oklahoma program was created to ease the burden for low-income uninsured or underinsured individuals who cannot afford their medications. This assistance is provided through the pharmaceutical companies, and while the RX for Oklahoma Program works to assist you in obtaining your medications, we also need you to do your part. While you are receiving assistance through the RX for Oklahoma program, you agree to.

- Provide any needed documentation (i.e. income, denial letters, copy of tax returns, etc.) to this office in a timely manner
- Notify the office as soon as possible if you receive correspondence, telephone calls or any communication from the pharmaceutical company
- Complete and return application to this office in a timely manner
- Notify this office of any address, phone number changes in a timely manner.
- Let this office know if any income or insurances changes should happen as soon as possible.
- The understanding that the assistance eligibility is final according to the pharmaceutical company's guidelines. The RX for Oklahoma advocate cannot overrule nor has any control over these guidelines.
- Provide this office with new proof of income at the start of every calendar year (i.e. income tax return, copy of social security award letter, or pay stubs)
- Understand that the office may contact you periodically to update your status or just check on how your assistance is going.

By signing this form, you agree to comply with these terms and conditions. If at any time you have any questions or concerns, please call your RX for Oklahoma Advocate. If you wish to withdraw from the program, please call the office and let us know as soon as possible. You may also be terminated from the RX for Oklahoma program for non-compliance.

Client agrees to term: DATE: _____

Printed name:

_____Signature:_____

This program is provided through a joint effort of Northeast Oklahoma Community Action 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 Services/ Homeless Assistance/ Deposit

___Rx for Oklahoma (Prescription Assistance)

___ New Eyes (Prescription Glasses 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 services you received improve you/ your family's stability? YES or NO (lower energy cost, ongoing medication need, eviction, etc.)
4. Will the services you received improve you/your family's immediate need?YES or NO? (Utility disconnection, eviction, etc.)

5. How did you hear 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 inform you of other services we offered Yes or No
9. Do you feel that your needs were met in a timely manner Yes or No
10. Please add any additional comments that you feel would help us serve you better.

_____

_____

_____

_____

This agency continues to offer new programs. Would you like to stay informed and receive our monthly newsletter? ____ YES or ____ NO

If yes, please supply us with your email address:

_____@_____

HIPAA RELEASE OF INFORMATION

AUTHORIZATION FORM

Name: _____ Date of Birth: _____

Release of information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child (ren) _____

[**X**] Other **Pharmaceuticals Patient Assistance Program**

[ ] information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing

Messages

Please call [ ] my home [ ] my work [ ] my cell number_____

If unable to reach me:

[ ] You may leave a detailed message

[ ] Please leave a message asking me to return your call

[ ] Other _____

The best Time to reach me is _____

Signed:_____ Date:_____

Witness:_____ Date:_____