609 East Peoria
P.O. Box 1023
McAlester, OK 74501
918-423-3525
866-213-4881

To apply for RX for Oklahoma, bring completed application and the following:

- Driver's License (Picture ID)
- Social Security Card
- Insurance Card(s) (if applicable)
- Federal Income Tax Return (1040)
- 1099 from Social Security (if applicable)
- 30 day Income Verification (check stubs, Social Security Income letter, etc.)
- SoonerCare (Medicaid) Denial Letter (if applicable)

If you qualify for the RX program, you should begin receiving your medicine within 4 weeks from the date the completed application is submitted.

KI BOIS Community Action Foundation, Inc.
609 East Peoria * PO Box 1023
McAlester, OK 74501
Ph: 918-423-3525 Fax: 918-423-0479
Toll Free: 866-213-4881

PLEASE PRINT ****PLEASE COPY ALL INSURANCE CARDS AND ATTACH FINANCIAL VERIFICATION****

Date: _____ **Have we assisted you before? YES NO**

Name: _____ _____ _____
(First) (MI) (Last)

Street Address: _____ **City:** _____

State: _____ **Zip:** _____ **County:** _____ **Phone:** (_____)_____

SSN: _____-_____-_____ **Sex:** _____ **Date of Birth:** _____

Household: ☐ **Head** ☐ **Spouse** ☐ **Dependent Child**

Employment Status: ☐ **Full** ☐ **Part** ☐ **Not in Labor Force** ☐ **Retired** ☐ **Unemployed**

Race: _____ **Marital Status:** _____ **Education Level:** _____

Are you a U.S. Citizen? YES NO Are you disabled? YES NO Do you have V.A. benefits? YES NO

How did you hear about this program? (Please circle one.)

Action Agency	Senior Advisor	Legislative Office	Community Clinic
Flyers	Newspaper	Social Services	PPARX
DHS	Friend/Family	Presentation	TV/Radio
Doctor's Office	Health Department	Website/Internet	Area Agency on Aging
Employer	Hospital	Word of Mouth	Other

Insurance Information: Please copy and attach ALL insurance cards, front and back, including Medicare and Medicaid.

Please check all that apply:

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

☐ Private Health Insurance (Company _____) ☐ None

Do you have prescription insurance for the medication you are requesting? YES NO

Number in household: Adults _____ Children _____ **Housing:** Own Rent Stay with Family/Friends

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

Please enter your MONTHLY household income from all sources - *Please Attach Financial Verification*

Wages $_____ Unemployment $_____ Workers Compensation $_____

Social Security Retirement $_____ Social Security Disability $_____

Other Disability $_____ Retirement $_____ Alimony/Child Support $_____

Other $_____ _____ **Total *Monthly* Household Income** $_____
(Specify Source)

Primary Physician Information:

Physician Name: _____ **Phone:** (_____)_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____ **Years with Physician:** _____

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

PRESCRIPTION 1 **Primary Physician** **YES** **NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone:** (_____)_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 2 **Primary Physician** **YES** **NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone:** (_____)_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 3 **Primary Physician** **YES** **NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone:** (_____)_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 4 **Primary Physician** **YES** **NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone:** (_____)_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 5 **Primary Physician YES NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone: (_____)_____**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 6 **Primary Physician YES NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone: (_____)_____**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 7 **Primary Physician YES NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone: (_____)_____**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 8 **Primary Physician YES NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone: (_____)_____**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

PRESCRIPTION 9 **Primary Physician YES NO**

Prescription Name: _____ **Dosage:** _____

Physician Name: _____ **Phone: (_____)_____**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

If you have more medications than space available, please ask for an additional prescription form or attach your own sheet with the required information.

Prescription Assistance Service
Rx for Oklahoma
KI BOIS Community Action Foundation, Inc.
609 East Peoria * PO Box 1023
McAlester, OK 74501
PH: 918-423-3525
Toll Free: 866-213-4881
FAX: 918-423-0479

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 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 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 the Prescription Assistance Service, *Rx for Oklahoma*, at 918-967-3365. 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 KI BOIS Community Action Foundation, Inc., the Oklahoma Department of Commerce, and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

Patient Consent and Release Form

Exchange of Information

I, _____, give authorization to the representatives of the 'RX for Oklahoma PAP' to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture and/or provide medications through patient assistance programs. I also authorize participating drug company(ies) to discuss me and my medication needs with my physician/advocate when necessary. This authorization is active until such time as I revoke this authorization.

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 and/or organization individually to give them information about me that they may need.

Date of Birth: _____ Social Security #: _____

Address: _____

Printed Name of Patient: _____

Signature: _____ Date: _____

Patient Signature Authorization

I authorize representatives of the 'RX for Oklahoma PAP' to sign forms on my behalf for the purposes of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is valid until such time as I revoke this authorization.

Printed Name of Patient: _____

Signature: _____ Date: _____

Allergy and Health Information

Client Name: _____ DOB: _____

Place an "X" in the box next to each allergy or health condition which applies to you.

Medication Allergies	
Codeine	
Sulfa	
Penicillin	
Tetracycline	
NO KNOWN ALLERGIES	
Other (please list)	
1.	
2.	
Food Allergies (please list)	
1.	
2.	
Health Conditions	
Diabetes	
Hypertension	
Heart Disease	
Glaucoma	
Stomach Disorders	
Thyroid Disease	
Arthritis	
NO KNOWN HEALTH CONDITIONS	
Other (please list)	
1.	
2.	

Patient Assistance Contract

Dear Client/Patient:

Certain pharmaceutical companies offer patient assistance programs to patients without prescription insurance coverage and/or cannot afford their medications and qualify under specific guidelines. The Rx for Oklahoma staff is here to assist with all the paperwork involved in the attempt to get you the assistance needed. You may be required to complete an application and/or answer questions by either the company and/or our staff.

While we do our best to locate assistance, we ask that you do your part in supplying the necessary documentation required to complete the applications 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 its own policy and financial guidelines that we must follow. Below are just a few of the items that we expect from you:

∗ **Provide proof of income.** This can be a copy of last year's tax return, a copy of your statement of benefit from Social Security, copies of the last four check stubs, or other documentation as the pharmaceutical company stipulates.

∗ **If you are accepted** into an assistance program, you medications will ship either to your doctor's office, your pharmacy or your home and you will be required to sign for it. Medications usually ship in a 90-day supply or less.

∗ **If you are NOT accepted** into an assistance program, you will be notified. Most companies notify with a denial letter sent to both you and your physician.

∗ **Notify the office** when you are down to a 30-day supply of medication. This will ensure that you receive your refill in a timely manner, since it can take the pharmaceutical company as long as three to four weeks to issue a refill. If you do not notify our office within this time frame, you may run out of your medication.

∗ **Notify our office** if your financial or insurance situation changes.

∗ **Notify our office** of any changes to your medications (no longer taking, dosing changes, etc.).

∗Over the counter medications available at your local pharmacies are more than likely not offered by assistance programs.

We ask that you read this document carefully and sign it if you understand and agree to comply with these requirements. A copy of this signed contract will be provided to you. If you have any questions, please do not hesitate to call our office.

Thank you for your understanding.

Signature: _____ Date: _____