RPMH
Prescription Assistance Program

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

Phone (325) 235-6824 Fax: (325) 235-3054

Date: _____

Dear Client: _____

Thank you for your interest in receiving assistance through Rolling Plains Memorial Hospital Prescription Assistance Program (RPMH PAP). 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. (You must reside in Nolan County)
- ☐ 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, 2016, 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. Please provide a printout of medication purchases from your pharmacy beginning January 1, 2016, to present.
- ☐ Copy of current Social Security Benefit Statement (Award Letter), VA Benefits, Retirement Benefits, Pension and bank statement showing Direct Deposit (must be current for 2016 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 2016 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 8:30 am and 2:30 pm, Tuesday through Thursday (excluding holidays).

Sincerely,

Vickie Cox

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