1215 Sidney Street, Suite 201
Batesville, AR 72501
870.698.9991

UAMS NORTH CENTRAL
UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

1200 South Main Street
Searcy, AR 72143
501.268.5000

2016

MEDICATION ASSISTANCE PROGRAM

Dear Client,

Enclosed are several forms to be filled out and returned to me in order to assist in applying for prescription assistance from various pharmaceutical companies' programs.

CLIENT INFORMATION REQUEST FORM: Please fill in the information requested. If more than one physician has prescribed your medications, please provide all the contact information on all those physicians. On the income source, please provide **THE GROSS INCOME (BEFORE ANY DEDUCTIONS) FOR EVERYONE LIVING IN THE SAME HOUSE WITH YOU.**

CONSENT AND AUTHORIZATION FORM: The Consent and Authorization form is a privacy/disclosure form that will allow me, if needed, to speak with your doctor(s) and/or any pharmaceutical company regarding your medications. Please print your name, sign, and date.

INFORMATION CHECKLIST: Please read over the checklist and provide copies of any documentation applicable to you **and your household**. Please provide a list of all the medications that you are taking. (Your pharmacist can print a listing of all your medications for you.) Also, please provide a list of allergies (food and/or medication). Please note on your medication list any medications covered by Medicaid or any other insurance.

When you have completed the attached application, you may take it to one of our UAMS North Central offices listed above or return the completed application by mail.

There will be a $10, non-refundable, administrative fee charged for the Medication Assistance Program each year upon enrollment and each year for renewal. Check or money order will need to be made payable to: UAMS North Central.

Please feel free to call if you have any questions.

Sincerely,

Rhonda J. Grantham
RJGrantham@uams.edu
Medication Assistance Program Coordinator
http://regionalprograms.uams.edu/regional-centers/uams-north-central/

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MEDICATION ASSISTANCE PROGRAM

CLIENT INFORMATION REQUEST

FIRST NAME _____ **MI** _____ **LAST NAME** _____

DATE OF BIRTH _____ **AGE** _____ **SSN** _____

ADDRESS _____**(Street address & PO Box)**

CITY _____ **STATE** _____ **ZIP**__ _____ **COUNTY** _____

HOME PHONE _____**OTHER PHONE** _____

DOCTOR _____ **PHONE** _____

CLINIC _____ **CITY & STATE** _____

DEMOGRAPHICS **Education Level:** _____

EMPLOYMENT STATUS: Full-time Part-time Retired Unemployed Disabled

MARITAL STATUS: Divorced Married Separated Single Widowed

RACE: White African American Asian Hispanic Native American Other

U.S. CITIZEN Yes No **U.S. Resident:** Yes No **ARE YOU A VETERAN?** Yes No

INSURANCE: Medicare Medicaid Both Private Other or Public None

MEDICATION COVERAGE **Yes** **No** **DID YOU FILE A TAX RETURN?** **Yes** **No**

ALLERGIES _____ **TOTAL ASSETS** _____(not home/autos)

HOUSEHOLD INFORMATION **ADULTS IN HOME** _____ **CHILDREN UNDER 18** _____ **TOTAL** _____

INCOME SOURCE	MONTHLY GROSS $	INCOME SOURCE	MONTHLY GROSS $$
WAGES		PUBLIC ASSISTANCE (i.e., Food Stamps, etc.)	
DISABILTY		INTEREST	
UNEMPLOYMENT		RENTAL PROPERTY	
SOCIAL SECURITY		INVESTMENTS	
WORKMEN'S COMP		SURIVOR BENEFITS	
ALIMONY		SOCIAL SECURITY DISABILITY	
CHILD SUPPORT		FAMILY ASSISTANCE	
RETIREMENT			
		TOTAL MONTHLY INCOME	

REFERRED BY: _____ **DATE:** _____

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MEDICATION ASSISTANCE PROGRAM

DOCUMENTATION CHECKLIST

PLEASE PROVIDE ANY OF THE DOCUMENTATION LISTED BELOW THAT APPLIES TO YOUR ENTIRE HOUSEHOLD (YOU AND ANYONE LIVING IN THE SAME HOUSE):

1. Copies of all cards (front and back): driver's license (picture ID if client has no DL); Social Security, and any and all insurance cards **(THESE ITEMS APPLY ONLY TO THE APPLICANT REQUESTING ASSISTANCE).**
2. Salary: copies of pay stubs for last 3 months, or a statement on letterhead from your employer showing your salary each month for the last 3 months.
3. Social Security (supplemental, disability, etc.) annual payment/benefits letter (or 1099 for previous year) (NO BANK STATEMENTS ACCEPTED.)
4. Unemployment Benefits (and, letter from employer showing last date worked)
5. Worker's compensation benefits
6. Child support
7. Alimony
8. Pension/Retirement
9. Veteran's benefits
10. Food Stamps (SNAP) or HUD housing assistance.
11. Contributions from family for assistance.
12. Proof of no income (letter from social worker, church, doctor, etc. dated and signed)
13. Copy of Medicaid denial issued within the past year.
14. Last year's income tax return (only pages 1 and 2 showing adjusted gross income).
15. Computerized print-out of all prescription activity for the current year (from January 1st until current date) from each of your pharmacies.

*****PLEASE KEEP THIS PAGE AS A REFERENCE FOR THE DOCUMENTS THAT ARE REQUIRED****

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Consent and Authorization for Release of Information for Medication Assistance Program

I certify that the information I have provided is accurate and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that I will have to provide other documents that are required as proof of income.

I authorize representatives of the UAMS North Central Medication Assistance Program to: 1) use and disclose my protected health information for the sole purpose of assisting me in securing my prescription drug(s) at little or no cost to me; 2) ask necessary information of my health care providers required to complete forms for medication assistance and to share this information with pharmaceutical companies as required; and, 3) complete and sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs.

This authorization will expire when my information is no longer required for my participation in the UAMS North Central Medication Assistance Program. I understand that I may revoke this authorization at any time by giving written notice to UAMS North Central Medication Assistance Program at: 1215 Sidney Street, Suite 201, Batesville, AR 72501. A revocation of this authorization will not apply to information already used or disclosed in reliance upon the authorization.

I understand that once the above information is disclosed, it may be re-disclosed by the designated recipient and the information may no longer be protected by Federal privacy laws and regulations.

UAMS North Central Medication Assistance Program will not condition treatment, payment, enrollment or eligibility for benefits on your signing of this authorization.

_____ _____

Printed Name of client or client's representative

Signature of client or client's representative

Date _____

_____ _____

Printed Name of UAMS NC Medication Assistance Program Representative

Signature of UAMS NC Medication Assistance Program Representative

Date_____

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LIST OF MEDICATIONS

CLIENT_____ DATE OF BIRTH _____

NAME/DOSE/FREQUENCY OF MEDICATION	PRESCRIBED BY	YOUR COST AT PHARMACY

HEALTH CONDITIONS: _____

_____

AMOUNT YOU HAVE SPENT ON YOUR OWN PRESCRIPTIONS SO FAR THIS YEAR_____