Thank you for your interest in the RX for Oklahoma Prescription Assistance Program! We look forward to helping you acquire your medications, however there are a few requirements that you should be aware of in order to process your assistance application.

A. Complete the attached application in its entirety. Leaving questions blank may lengthen the application process.

B. You *MUST* provide a copy of the following items*:*

1. Proof of current income for (3) three months (Pay Stubs, Unemployment Compensation, Child Support, Alimony, Disability Determination Letter, Social Security Supplemental Income Letter, or any other income)
2. Income taxes from the previous year if applicable
3. Current Health/Prescription Insurance cards if any

You may return the completed application to either by mail, fax, or in person. If you have any questions or need assistance in completing the application, please don't hesitate to contact us.

Latimer County

Amy Fair – 918-470-2760 – amy.fair@kibois.org Stephanie McCann – 918-471-8861 -- stephanie.mccann@kibois.org	Office: 918-465-3381 Fax: 918-465-3053 309 W. Main Street, Wilburton, OK 74578

Pittsburg County

Megan Reames – megan.reames@kibois.org	Office: 918-423-3525 / 866-213-4481 Fax: 918-426-0479 609 E. Peoria, McAlester, OK 74502

Sequoyah County

Tanya Harrison – tanya.harrison@kibois.org	Office: 918-776-0848 Fax: 918-776-0806 1206 W. Redwood, Sallisaw, OK 74955

Haskell County

Nikki Morrison -- nikki.capehart@kibois.org	Office: 918-967-3325 / 800-299-4479 Fax: 918-967-8660 200 S.E. A Street, Stigler, OK 74462

LeFlore County

Rosalind Newby – rosalind.newby@kibois.org	Office: 918-647-3267 / 866-341-3381 Fax: 918-647-3268 219 Kerr Avenue, Poteau, OK 74953

*** If your county of residence is not listed, please contact: ***
Amy Fair, Rx for Oklahoma Director – Region 4
918-470-2760 / amy.fair@kibois.org

Revised: 03/17/2025

KI BOIS COMMUNITY ACTION FOUNDATION, INC.

CUSTOMER INFORMATION
PRIMARY APPLICANT (PERSON COMPLETING THIS FORM)

Please complete a new form for <u>each</u> additional member of your household.

Last Name	First Name	Date of Birth	Today's Date
Phone ( )	Email	SSN	Office Location
Address	City		Zip Code

GENDER
☐ Male ☐ Other
☐ Female

MARITAL STATUS
☐ Single ☐ Separated
☐ Married ☐ Divorced

ETHNICITY
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

INDICATE YOUR RACE (SELECT ONE)
☐ American Indian/Alaskan Native ☐ Black/African American ☐ Hawaiian/Pacific Islander
☐ Asian ☐ Caucasian (White) ☐ Multi-Race ☐ Other

INDICATE YOUR EDUCATION (SELECT ONE)
☐ 0-8th Grade ☐ GED ☐ Graduate of other post-secondary school
☐ 9-12 Education ☐ 12+ Some Postsecondary
☐ High School Graduate ☐ 2 or 4 Year Degree

INDICATE YOUR HEALTH INSURANCE (SELECT ONE)
☐ No Health Insurance ☐ Medicaid ☐ Sooner Care
☐ Direct Purchase ☐ Medicare ☐ Indian Health Services
☐ Employment Based ☐ Military Health Care

MILITARY STATUS (SELECT ONE)
☐ Active Military ☐ No Status
☐ Veteran

ARE YOU DISABLED?
☐ Yes
☐ No

EDUCATION/EMPLOYMENT STATUS
☐ Not working/Not in School
☐ Working/Not in School
☐ In School/Not working

WORK STATUS (SELECT ONE)
☐ Employed Full-Time ☐ Unemployed (Long-Term)
☐ Employed Part-Time ☐ Unemployed (Not in Workforce)
☐ Migrant Seasonal Farm Worker ☐ Unemployed Short Term >6mos
☐ Retired

DO YOU HAVE A CDIB CARD?
☐ Yes
☐ No
Which Nation:_____

NON-CASH BENEFITS (SELECT ALL THAT APPLY)
☐ Affordable Care Act Subsidy ☐ LIHEAP ☐ None-No Need
☐ Childcare Voucher ☐ TANF ☐ None-Not Applied
☐ SNAP (Food Stamps) ☐ WIC/Tribal WIC ☐ None- Do Not Qualify
☐ Section 8 Housing ☐ Tribal Commodities

SELECT INCOME SOURCE(S) AND INDICATE YOUR *<u>MONTHLY</u>* INCOME AMOUNT(S):
☐ Employment_____ ☐ None ☐ Social Security_____
☐ TANF_____ ☐ Pension_____ ☐ SSDI_____
☐ Public Assistance _____ ☐ Alimony_____ ☐ SSI_____
☐ Child Support _____ ☐ Rental_____ ☐ Veterans_____
☐ Self-Employment_____ ☐ Interest/Dividends_____ ☐ Work Comp_____

HOUSING STATUS (SELECT ONE)
☐ Rent ☐ Own ☐ Homeless ☐ Other Permanent Housing ☐ Other:_____

HOUSEHOLD TYPE (SELECT ONE)
☐ Single Person ☐ Male Single Parent ☐ Multigenerational Household
☐ Two Adults NO Children ☐ Two Parent Household ☐ Other
☐ Female Single Parent ☐ Non-related Adults W/ Children

KI BOIS Community Action Partnership
Helping People. Changing Lives.
America's Poverty Fighting Network

Rx for Oklahoma

Turn Over and Complete!

Additional Rx for Oklahoma Information:

County: _____

Household:

☐ **Head** ☐ **Spouse** ☐ **Dependent Child**

Did you file a tax return last year? ☐ **YES** ☐ **NO**

Are you a U.S. Citizen? ☐ **YES** ☐ **NO**

How did you hear about Rx for Oklahoma?

☐ 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 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**

**** Please copy and attach ALL insurance cards, front and back, including Medicare and Medicaid ****

APPLICANT RIGHTS AND RESPONSIBILITIES: I understand that I have the right to a fair hearing of any action directly concerning this application. I certify that I have read completely this application, or that it has been read to me. I further certify that all information contained herein is true. I understand that this authorization does not relieve me from full responsibility for the information contained on this application. I also certify that a false representation made by me for the purpose of obtaining services makes me subject to prosecution under penalty of law. I also authorize KI BOIS Community Action Agency to make any and all inquiries to verify the answers I have given, such as release of information listed above to other agencies on my behalf for the purpose of verification in connection with any assistance that may be provided to me.

APPLICANT'S SIGNATURE: _____

DATE: _____

INTERVIEWER'S NAME: _____

DATE: _____

KCAF 12/12/17

Prescription Assistance Service
Rx for Oklahoma
KI BOIS Community Action Foundation, Inc.
200 S.E. A Street
Stigler, OK 74462
PH: 918-967-3325
FAX: 918-967-8660

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 918-465-3381. 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 State Department of Health, 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_____, **Patient Advocate with 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, give authorization to_____, Patient Advocate with 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: _____

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: _____

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.	

Primary Physician / Provider Information:

Name:_____ **Phone: (___)**_____

Street Address: _____

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

List of prescriptions you are seeking assistance with:

PRESCRIPTION 1

Prescription Name:_____

Dosage: _____

PRESCRIPTION 2

Prescription Name:_____

Dosage: _____

PRESCRIPTION 3

Prescription Name:_____

Dosage: _____

PRESCRIPTION 4

Prescription Name:_____

Dosage: _____

PRESCRIPTION 5

Prescription Name:_____

Dosage: _____

PRESCRIPTION 6

Prescription Name:_____

Dosage: _____

PRESCRIPTION 7

Prescription Name:_____

Dosage: _____

PRESCRIPTION 8

Prescription Name: _____

Dosage: _____

PRESCRIPTION 9

Prescription Name: _____

Dosage: _____

PRESCRIPTION 10

Prescription Name: _____

Dosage: _____

PRESCRIPTION 11

Prescription Name: _____

Dosage: _____

PRESCRIPTION 12

Prescription Name: _____

Dosage: _____

PRESCRIPTION 13

Prescription Name: _____

Dosage: _____

PRESCRIPTION 14

Prescription Name: _____

Dosage: _____

PRESCRIPTION 15

Prescription Name: _____

Dosage: _____