



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 – <a href="mailto:amy.fair@kibois.org">amy.fair@kibois.org</a> Stephanie McCann – 918-471-8861 -- <a href="mailto:stephanie.mccann@kibois.org">stephanie.mccann@kibois.org</a>	Office: 918-465-3381 Fax: 918-465-3053 309 W. Main Street, Wilburton, OK 74578
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### Pittsburg County

Megan Reames – <a href="mailto:megan.reames@kibois.org">megan.reames@kibois.org</a>	Office: 918-423-3525 / 866-213-4481 Fax: 918-426-0479 609 E. Peoria, McAlester, OK 74502
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### Sequoyah County

Tanya Harrison – <a href="mailto:tanya.harrison@kibois.org">tanya.harrison@kibois.org</a>	Office: 918-776-0848 Fax: 918-776-0806 1206 W. Redwood, Sallisaw, OK 74955
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### Haskell County

Christi Dixon -- <a href="mailto:christi.dixon@kibois.org">christi.dixon@kibois.org</a>	Office: 918-967-3325 / 800-299-4479 Fax: 918-967-8660 200 S.E. A Street, Stigler, OK 74462
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### LeFlore County

Rosalind Newby – <a href="mailto:rosalind.newby@kibois.org">rosalind.newby@kibois.org</a>	Office: 918-647-3267 / 866-341-3381 Fax: 918-647-3268 219 Kerr Avenue, Poteau, OK 74953
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\*\*\* 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](mailto:amy.fair@kibois.org)

<b>CUSTOMER INFORMATION</b>			<i>Please complete a new form for <u>each</u> additional member of your household.</i>		
<b>PRIMARY APPLICANT (PERSON COMPLETING THIS FORM)</b>					
Last Name	First Name	Date of Birth	Today's Date		
Phone (    )	Email	SSN	Office Location		
Address		City	Zip Code		
<b>GENDER</b>		<b>MARITAL STATUS</b>		<b>ETHNICITY</b>	
<input type="checkbox"/> Male <input type="checkbox"/> Other	<input type="checkbox"/> Single	<input type="checkbox"/> Separated	<input type="checkbox"/> Hispanic/Latino		
<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Non-Hispanic/Latino		
<b>INDICATE YOUR RACE (SELECT ONE)</b>					
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hawaiian/Pacific Islander			
<input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian (White)	<input type="checkbox"/> Multi-Race	<input type="checkbox"/> Other		
<b>INDICATE YOUR EDUCATION (SELECT ONE)</b>					
<input type="checkbox"/> 0-8 <sup>th</sup> Grade	<input type="checkbox"/> GED	<input type="checkbox"/> Graduate of other post-secondary school			
<input type="checkbox"/> 9-12 Education	<input type="checkbox"/> 12+ Some Postsecondary				
<input type="checkbox"/> High School Graduate	<input type="checkbox"/> 2 or 4 Year Degree				
<b>INDICATE YOUR HEALTH INSURANCE (SELECT ONE)</b>					
<input type="checkbox"/> No Health Insurance	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Sooner Care			
<input type="checkbox"/> Direct Purchase	<input type="checkbox"/> Medicare	<input type="checkbox"/> Indian Health Services			
<input type="checkbox"/> Employment Based	<input type="checkbox"/> Military Health Care				
<b>MILITARY STATUS (SELECT ONE)</b>		<b>ARE YOU DISABLED?</b>		<b>EDUCATION/EMPLOYMENT STATUS</b>	
<input type="checkbox"/> Active Military	<input type="checkbox"/> No Status	<input type="checkbox"/> Yes	<input type="checkbox"/> Not working/Not in School		
<input type="checkbox"/> Veteran		<input type="checkbox"/> No	<input type="checkbox"/> Working/Not in School		
			<input type="checkbox"/> In School/Not working		
<b>WORK STATUS (SELECT ONE)</b>			<b>DO YOU HAVE A CDIB CARD?</b>		
<input type="checkbox"/> Employed Full-Time	<input type="checkbox"/> Unemployed (Long-Term)	<input type="checkbox"/> Yes			
<input type="checkbox"/> Employed Part-Time	<input type="checkbox"/> Unemployed (Not in Workforce)	<input type="checkbox"/> No			
<input type="checkbox"/> Migrant Seasonal Farm Worker	<input type="checkbox"/> Unemployed Short Term >6mos	Which Nation: _____			
<input type="checkbox"/> Retired					
<b>NON-CASH BENEFITS (SELECT ALL THAT APPLY)</b>					
<input type="checkbox"/> Affordable Care Act Subsidy	<input type="checkbox"/> LIHEAP	<input type="checkbox"/> None-No Need			
<input type="checkbox"/> Childcare Voucher	<input type="checkbox"/> TANF	<input type="checkbox"/> None-Not Applied			
<input type="checkbox"/> SNAP (Food Stamps)	<input type="checkbox"/> WIC/Tribal WIC	<input type="checkbox"/> None- Do Not Qualify			
<input type="checkbox"/> Section 8 Housing	<input type="checkbox"/> Tribal Commodities				
<b>SELECT INCOME SOURCE(S) AND INDICATE YOUR <u>MONTHLY</u> INCOME AMOUNT(S):</b>					
<input type="checkbox"/> Employment _____	<input type="checkbox"/> None	<input type="checkbox"/> Social Security _____			
<input type="checkbox"/> TANF _____	<input type="checkbox"/> Pension _____	<input type="checkbox"/> SSDI _____			
<input type="checkbox"/> Public Assistance _____	<input type="checkbox"/> Alimony _____	<input type="checkbox"/> SSI _____			
<input type="checkbox"/> Child Support _____	<input type="checkbox"/> Rental _____	<input type="checkbox"/> Veterans _____			
<input type="checkbox"/> Self-Employment _____	<input type="checkbox"/> Interest/Dividends _____	<input type="checkbox"/> Work Comp _____			
<b>HOUSING STATUS (SELECT ONE)</b>					
<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Homeless <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other: _____					
<b>HOUSEHOLD TYPE (SELECT ONE)</b>					
<input type="checkbox"/> Single Person	<input type="checkbox"/> Male Single Parent	<input type="checkbox"/> Multigenerational Household			
<input type="checkbox"/> Two Adults NO Children	<input type="checkbox"/> Two Parent Household	<input type="checkbox"/> Other			
<input type="checkbox"/> Female Single Parent	<input type="checkbox"/> Non-related Adults W/ Children				



<b>Additional Rx for Oklahoma Information:</b>			
County: _____		<b>Household:</b>	
Did you file a tax return last year? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Head	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child
		Are you a U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>How did you hear about Rx for Oklahoma?</b>			
<input type="checkbox"/> Action Agency	<input type="checkbox"/> Senior Advisor	<input type="checkbox"/> Legislative Office	<input type="checkbox"/> Community Clinic
<input type="checkbox"/> Flyers	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Social Services	<input type="checkbox"/> PPARX
<input type="checkbox"/> DHS	<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Presentation	<input type="checkbox"/> TV/Radio
<input type="checkbox"/> Doctor's Office	<input type="checkbox"/> Health Department	<input type="checkbox"/> Website/Internet	<input type="checkbox"/> Area Agency on Aging
<input type="checkbox"/> Employer	<input type="checkbox"/> Hospital	<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> Other
<b>Insurance Information:</b>			
<b>Please check all that apply:</b>			
<input type="checkbox"/> Medicare (Medicare # _____)	<input type="checkbox"/> Medicare Discount Card	<input type="checkbox"/> Medicaid	
<input type="checkbox"/> Private Health Insurance (Company _____)	<input type="checkbox"/> None		
<b>Do you have prescription insurance for the medication you are requesting?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<i>*** Please copy and attach ALL insurance cards, front and back, including Medicare and Medicaid ***</i>			

**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:** \_\_\_\_\_



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 918-967-3365. 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.

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Client signature

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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 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, your 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: \_\_\_\_\_



## 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: \_\_\_\_\_



## Allergy and Health Information

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

<b>Medication Allergies</b>	
Codeine	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>
Tetracycline	<input type="checkbox"/>
NO KNOWN ALLERGIES	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
<b>Food Allergies (please list)</b>	
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
<b>Health Conditions</b>	
Diabetes	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>
Stomach Disorders	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>
NO KNOWN HEALTH CONDITIONS	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>

**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: \_\_\_\_\_

