



## *DOCUMENTATION NEEDED WITH COMPLETED Rx APPLICATION*

- Drivers 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)

Korie Asenap, Program Coordinator  
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105 S. Main/PO Box 989  
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Phone: 580-335-5588/1-866-511-0938  
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For faster service, please call for an appointment!



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Please Print

**\*\* MUST PROVIDE COPY OF INS. CARDS AND FINANCIAL DOCUMENTATION TO PROCESS\*\***

Date: \_\_\_\_\_ Have we assisted you before? YES NO  
 Name: \_\_\_\_\_ (First) (MI) (Last)

Street/Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Language: \_\_\_\_\_

Household: \_\_\_ Head \_\_\_ Spouse \_\_\_ Dependent Child

Employment Status: \_\_\_ Full \_\_\_ Part \_\_\_ Not in Labor Force \_\_\_ Retired \_\_\_ Unemployed

Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Education Level: \_\_\_\_\_

U. S. Citizen? YES NO U.S. Resident? Yes No Disabled? YES NO Veteran? YES NO

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

- |               |                         |                  |                 |
|---------------|-------------------------|------------------|-----------------|
| CADC          | Community Clinic Flyers | Newspaper        | Social Services |
| United Way    | DHS/Health Department   | Friend/Family    | Presentation    |
| TV/Radio      | Doctor's Office         | Website/Internet | Hospital        |
| Word of Mouth | Other: _____            |                  |                 |

**Insurance Information: PLEASE COPY AND ATTACH ALL INSURANCE CARDS, FRONT AND BACK**

Please mark all that apply:

\_\_\_\_\_ Medicare (Medicare # \_\_\_\_\_) Are you eligible for Medicare Part D? YES NO

\_\_\_\_\_ SoonerCare (Medicaid)

\_\_\_\_\_ Private Health Insurance (Company \_\_\_\_\_)

\_\_\_\_\_ None

Do you have prescription Insurance? YES NO

Have you applied for SoonerCare (Medicaid) in the past 12 months? YES NO

Have you been denied for SoonerCare (Medicaid) in the past 12 months? 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

Salary/Wages \$ \_\_\_\_\_ Unemployment/Work Comp. \$ \_\_\_\_\_ SSD/SSI \$ \_\_\_\_\_

Social Security Retirement \$ \_\_\_\_\_ Alimony/Child Support \$ \_\_\_\_\_ Pension/Retirement \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Total *Monthly* Household Income \$ \_\_\_\_\_



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## RELEASE FORM

*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 *Rx for Oklahoma* 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 580-335-5588. 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 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 Community Action Development Corporation and the Oklahoma Department of Commerce, and the State of Oklahoma with special thanks to the Oklahoma Pharmacy Connection Council.

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.

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PRESCRIPTION 1 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Primary Physician YES NO

Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

RX Office Use Only  
PAP: \_\_\_\_\_  
Phone: \_\_\_\_\_

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PRESCRIPTION 2 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Primary Physician YES NO

Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

RX Office Use Only  
PAP: \_\_\_\_\_  
Phone: \_\_\_\_\_

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PRESCRIPTION 3 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Primary Physician YES NO

Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

RX Office Use Only  
PAP: \_\_\_\_\_  
Phone: \_\_\_\_\_

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PRESCRIPTION 4 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Primary Physician YES NO

Physician Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

RX Office Use Only  
PAP: \_\_\_\_\_  
Phone: \_\_\_\_\_

PRESCRIPTION 5 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Primary Physician YES NO

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: \_\_\_\_\_

RX Office Use Only

PAP: \_\_\_\_\_

Phone: \_\_\_\_\_

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PRESCRIPTION 6 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Primary Physician YES NO

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: \_\_\_\_\_

RX Office Use Only

PAP: \_\_\_\_\_

Phone: \_\_\_\_\_

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PRESCRIPTION 7 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Primary Physician YES NO

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: \_\_\_\_\_

RX Office Use Only

PAP: \_\_\_\_\_

Phone: \_\_\_\_\_

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PRESCRIPTION 8 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Primary Physician YES NO

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: \_\_\_\_\_

RX Office Use Only

PAP: \_\_\_\_\_

Phone: \_\_\_\_\_

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PRESCRIPTION 9 \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Primary Physician YES NO

Physician Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone: \_\_\_\_\_

RX Office Use Only

PAP: \_\_\_\_\_

Phone: \_\_\_\_\_



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### 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 KNOW 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 KNOW HEALTH CONDITIONS	
Other (please list)	
1.	
2.	



# Self Declaration of Income

I, \_\_\_\_\_, declare that I am not working at this time and do not receive any type of income.

Do you receive any other form of assistance?

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How do you meet your everyday needs (food, rent, utilities, etc.)?

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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\*\* Office Use ONLY\*\*

I witness that this client has no documentation for proof of income:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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

Printed Name of Advocate: \_\_\_\_\_

Advocate 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, 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.

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Patient Signature

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Date