BEHAVIORAL HEALTH MEDICATION ASSISTANCE PROGRAM

SafeNetRx™
CHARITABLE PHARMACY

APPLY ONLINE AT
WWW.PORTAL.SAFENETRX.ORG

PROVIDES FREE 30-DAY SUPPLIES

of covered medications for up to 6-months with a valid prescription through our mail-order pharmacy

ELIGIBILITY

- ☐ Recently released from state or local law enforcement (within the past 3 years)
- ☐ Living in the state of Iowa
- ☐ Annual Household Income at or below the following:

PERSONS IN HOUSEHOLD	ANNUAL INCOME
1	$30,120
2	$40,880
3	$51,640
4	$62,400
5	$73,160
6	$83,920
7	$94,680
8	$105,440

These numbers were last updated on 2/1/24

COVERED MEDICATIONS

ANTIANXIETY
Buspirone
Diphenhydramine
Hydroxyzine
Propranolol
Clonidine
Melatonin
Gabapentin

ANTIDEPRESSANT
Amitriptyline
Bupropion
Citalopram
Doxepin
Duloxetine
Escitalopram
Fluoxetine
Imipramine
Mirtazapine
Nortriptyline
Paroxetine
Sertraline
Trazodone
Venlafaxine

ANTIPSYCHOTIC
Aripiprazole
Haloperidol
Olanzapine
Perphenazine
Quetiapine
Risperidone
Ziprasidone

MOOD STABILIZER
Carbamazepine
Divalproex
Lamotrigine
Lithium

EPS/PTSD/SUD
Benztropine
Cyproheptadine
Naltrexone
Prazosin
Trihexyphenidyl
Topiramate

ADHD/NARCOLEPSY
Atomoxetine
Guanfacine

Other medications may be covered based on availability

GET STARTED TODAY!

APPLY ONLINE
at www.portal.safenetrx.org OR complete the application provided with this flyer

PRESCRIPTIONS
Have your doctor send us your prescription information or let us know if you have refills at another pharmacy

CONTACT US
Give the pharmacy a call to start using the program and we will ship the medications directly to your home

Need help finding a provider but lack insurance to cover the cost? Visit fciowa.org to find a list of free clinics near you!

IOWA DEPARTMENT OF JUSTICE · OFFICE OF THE ATTORNEY GENERAL

(515) 276-0066 pharmacy@safenetrx.org www.safenetrx.org

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MEDICATION ASSISTANCE APPLICATION

Full Name : _____
First Name *Middle Initial* *Last Name*

Date of Birth : ____ / ____ / ____ **Gender :** ☐ Male ☐ Female **Allergies :** _____

Shipping Address : _____
Street Address *Apt/Unit #*

_____
City, State, Zip-Code

Phone Number : _____ ext **E-Mail Address :** _____

Current Medications: _____

_____

Current Pharmacy: _____

Have you previously been incarcerated or placed under state or local supervision within the past 3 years?
If yes, please answer the following questions:

Name of Prison or County Jail released from : _____ **Approximate Release Date :** ____ / ____ / ____

Booking ID (ICON #) : _____ **Parole/Probation Officer Name:** _____

ELIGIBILITY DETAILS *Valid for one year from date enrolled*

I am currently living in the state of Iowa : ☐ Yes ☐ No

Annual Household Income ($) : _____

I am unable to afford my medications because (check one) :

☐ I do not have insurance ☐ I have insurance but cannot afford my co-pay

Number of Individuals in Household (#) : _____

APPLICANT/REPRESENTATIVE AUTHORIZATION

I certify that all of the above information is true and correct as of the date shown below. I understand that this information is to be used to determine eligibility for donated medications and that any misrepresentation herein will terminate the above applicant's ability to receive medications from SafeNetRx Pharmacy. I understand SafetNetRx may contact me in the future to verify this information.
I authorize the release of the provided information necessary for audit purposes to program administrators or third-party designees to verify eligibility for medication donation programs or access public records for an evaluation of the SafeNetRx program and permit the following to be used in place of this original document: (1) a photocopy of this authorization, or (2) use of a computer to indicate a signature is on file.
I understand I have a right to review SafeNetRx's Notice of Privacy Practices prior to signing this document. SafeNetRx's Notice of Privacy Practices has been offered for me to view online at safenetrx.org. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information. SafeNetRx reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing SafeNetRx's website or calling the pharmacy and requesting a revised copy be sent in the mail.

SEND COMPLETED APPLICATION TO:

Email: pharmacy@safenetrx.org
Fax: (515) 401-1191

THANK YOU!

SAFENETRX CHARITABLE PHARMACY

Phone: (515) 276-0066

_____
SIGNATURE ☐ *Check box if you are a representative signing on behalf of the applicant with the applicant's verbal permission*

_____
DATE