



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	\$27,180
2	\$36,620
3	\$46,060
4	\$55,500
5	\$64,940
6	\$74,380
7	\$83,820
8	\$93,260

COVERED MEDICATIONS

ANTI-ANXIETY

Buspirone
 Diphenhydramine
 Hydroxyzine
 Propranolol
 Clonidine
 Melatonin

ANTIDEPRESSANT

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

ANTI-PSYCHOTIC

Aripiprazole
 Haloperidol
 Olanzapine
 Perphenazine
 Quetiapine
 Risperidone
 Ziprasidone

MOOD STABILIZER

Carbamazepine
 Divalproex
 Lamotrigine
 Lithium

EPS/PTSD

Benzotropine
 Cyproheptadine
 Naltrexone
 Prazosin
 Trihexyphenidyl

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!





BEHAVIORAL HEALTH MEDICATION ASSISTANCE PROGRAM APPLICATION

SafeNetRx™ CHARITABLE PHARMACY

APPLY ONLINE AT
WWW.PORTAL.SAFENETRX.ORG



APPLICANT INFORMATION

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 : _____

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

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

Current Medications : _____

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 _____

