

**Patient Eligibility Form**

Name (print)		Gender	Date of Birth
Address		Telephone Number	
City	State	Zip Code	

**I am currently a resident of the state of Iowa.** Yes    No

**I am unable to afford my Prescription regardless of insurance coverage.** Yes    No

**I understand the Prescription received has been donated.** Yes    No

**I understand the medications are not in a child safe container and waive my rights to the Poison Prevention Packaging Act.** Yes    No

\_\_\_\_\_  
**Signature of Applicant or Representative** **Date**

By my signature, I certify that all information on this form is accurate and complete. I understand SafetNetRx may contact me in the future to verify this information. If the information I have provided is incomplete or inaccurate, and I do not meet the eligibility requirements any services I request may be denied.

Further, I understand that the pharmacy, pharmacist, clinic, and others involved with this program cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.

# of Individuals in Household	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
<b>For families/households with more than 8 persons</b>	<b>Add \$4,720 for each additional person</b>

**Privacy Policy**  
 SafeNetRx will take all appropriate steps to keep any personal information you share with us confidential. SafeNetRx will not sell, rent, or give away personal information gathered for use in selling other company's products or services. Any information we do gather will be used to improve our relationships with our members. If you have any questions about this privacy policy, you may contact us at repository@safenetrx.org, or call toll-free at 1-866-282-5817 M-F 8:00a.m. to 4:30p.m. CST.

**My family income is at or below the above levels.** ↑ Yes No