MEDICATION ASSISTANCE

SafeNetRx™
CHARITABLE PHARMACY

APPLY ONLINE AT
WWW.PORTAL.SAFENETRX.ORG

PROVIDING LOW-COST MEDICATIONS TO IOWANS IN NEED

ELIGIBILITY

- [ ] Living in the state of Iowa
- [ ] Unable to afford your prescribed medication regardless of insurance status
- [ ] Annual Household Income at or below the following:

PERSONS IN HOUSEHOLD	ANNUAL INCOME
1	$31,300
2	$42,300
3	$53,300
4	$64,300
5	$75,300
6	$86,300
7	$97,300
8	$108,300

These numbers were last updated 1/27/25

PRICING
FOR EACH 30-DAY SUPPLY PRESCRIPTION

GENERIC — $5
We have over 200 generic medications available covering most disease states

BRAND-NAME — $15
Donated brand-name products and inhalers are available on a limited basis

MEDICAL SUPPLIES — $15
Ask about our inventory of medical supplies such as insulin syringes, pen needles, and lancets

Pricing includes shipping. Brand-name medications are limited to no more than 6-months per patient.

GET STARTED TODAY!

APPLY ONLINE
OR complete the application provided with this flyer. *Please note that we do not fill prescriptions for controlled substances or those requiring refrigeration (insulin).*

PRESCRIPTIONS
Have your doctor send us your prescription information or let us know if you have refills at another pharmacy.
Surescripts NCPDP 1625574
Fax (515) 401-1191

PAYMENT
Payment must be made before medications are shipped. Debit/Credit information can be taken over the phone or via a secure web page.

SHIPPING
Your shipping address must be confirmed before shipping. Once shipped, you should receive your prescriptions within 3-5 business days.

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

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

Normal Operating Hours: Monday - Thursday 8:30AM - 4:30PM and Friday 8:00AM - 12:00PM

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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 under a 23-hour hold for crisis observation within the past 3 years? If yes, please answer the following questions:

Name of prison, county jail or medical facility : _____ **Approximate Release Date :** ____ / ____ / ____

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

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