Medication Assistance Application

Send completed form and accompanying documents to SafeNetRx Pharmacy Fax:(515) 401-1191
Email: pharmacy@safenetrx.org

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email: _____

Date of Birth: _____ Allergies: _____ Case Manager Phone Number: _____

Current Medications: _____

Residence Information

I hereby attest that I am currently living in the state of Iowa. YES ☐ NO ☐

I hereby attest that I am currently homeless. YES ☐ NO ☐

Attach copy of supporting document (driver's license, state ID, tax forms, or a utility bill showing an IA address, SNAP card, etc)

Income Information

I hereby attest that my total estimated annual income from wages and other sources is: $_____

Number of individuals in household:_____

Attach copy of supporting document (tax return, W-2 form, letter from employer showing compensation, recent paycheck stub, unemployment statement, social security statement, SNAP card, etc)

Insurance Information

I am covered by (choose one):
- ☐ Commercial insurance with prescription drug coverage or pharmacy benefits
- ☐ Veteran's assistance
- ☐ Medicare or Medicaid
- ☐ Any other federal health care program
- ☐ I do not have health insurance

I lack prescription drug coverage/pharmacy benefits or am unable to afford the prescription co-pay. YES ☐ NO ☐

Patient Attestation – Valid for one year from date enrolled

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 my ability to receive medications from SafeNetRx-Pharmacy. I will notify SafeNetRx immediately of any changes in employment, income or insurance prior to having additional prescriptions filled. I acknowledge that I may not seek payment from any third-party payor, including federal health care programs such as Medicare or Medicaid, for any Program Products received from SafeNetRx.

Signature: _____ Date: _____

SafeNetRx Pharmacy HIPAA Notice

I authorize release of any medical information necessary for audit purposes to program administrators or third-party designees to verify eligibility for medication donation programs, or to process this (these) claim(s) by third-party payors and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability third-party claims:

(1) a photocopy of other facsimile reproduction of this authorization, or

(2) use of a computer to indicate my signature is on file, and/or use of a computer to electronically transmit my claim for processing.

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 provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of SafeNetRx on SafeNetRx's website at safenetrx.org. This Notice of Privacy Practices also describes my rights and SafeNetRx duties with respect to 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 office and requesting a revised copy be sent in the mail.

Signature: _____ Date: _____

Staff Signature & Acknowledgement

I verify that I am working within my professional capacity and that the patient's identity and eligibility for the SafeNetRx Behavioral Health Medication Assistance Program has been validated.

Staff Name & Title (Print) _____

Staff Signature: _____ Date: _____

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SafeNetRx Pharmacy
pharmacy@safenetrx.org
P: (515) 276-0066
F: (515) 401-1191