IMPROVING ACCESS TO LIFE-SAVING MEDICATIONS ONE PATIENT AT A TIME

ALLIANCE for PHARMACEUTICAL ACCESS

**ENGLISH**

**Main office location:**
506 E. Plaza Drive, Santa Maria, Suite #5, CA 93454 / Direct: (805) 614-2040 Fax: (805) 614-2010
www.apameds.org
**Mailing Address:** 237 Town Center West #122 Santa Maria, CA 93454

First Name_____(Middle Int.)_____Last Name_____

Address_____City: _____State:_____Zip:_____

Home Phone (_____) _____ Cell (_____) _____

Date of Birth _____/_____ /_____Age_____ Social Security #_____

*Emergency contact*: Name:_____ Phone _____
*Relationship*: _____
Does this person have permission to access information about your case? □ Yes □ No

*How did you hear about us or who were you referred by*? _____

Gender: F□ M□ Marital Status: Single □ Married □ Divorced □ Separated □ Widowed □

Ethnicity**:** White □ Latino/a □ Hispanic □ Asian □ Native American □
African American □ Other □ _____

Please list all sources of income starting with your own and then your spouse or other contributor of income:

Occupation: _____ and name of Employer:_____
Your source of Income: (wages, social security, disability, unemployment, cash aid, pension, child support, etc)
*Indicate each source and gross amount below:*

_____

Do you get paid weekly, every 2 weeks, bi-weekly or monthly? _____
Other income from assets/rentals:_____

Spouse's or other contributor of income**:** (wages, social security, disability, unemployment, cash aid, pension, child support, etc) *Indicate each source and gross amount below:*

_____

How often does he/she get paid? weekly, bi-weekly or
monthly?_____Other income from assets/rentals:_____

Any other contributor of income**:** (wages, social security, disability, unemployment, cash aid, pension, child support, etc)
*Indicate each source and gross amount below:*
How often does he/she get paid? weekly, bi-weekly or monthly?_____
Other income from assets/rentals:_____

How many dependents do you have in your household (children under the age of 18) #_____

May we contact you via E-mail? □Yes □No E-mail address:_____

**Month_____/2017**
Revised 5/2017

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# Insurance Information

Private Insurance, Covered California, or Employer sponsored ☐Yes ☐No

Insurance Company name: _____Phone #:_____

Policy Number: _____Group No.:_____

***Does it cover medications? ☐ Yes ☐ No

Medicare: No ☐ Yes ☐ If yes, please check all that apply: A ☐ B ☐ / Part D ☐ (drug coverage)
*(For Hospital and Doctor Visits) Part A & B (For Medication coverage) Part D*

Do you use any mail order pharmacies such as (Humana) Right Source or Express Scripts ☐ Yes ☐ No

Do you use more than one local pharmacy to purchase medications? ☐ Yes ☐ No

Are you enrolled in a Part C Plan /Supplemental Medicare Advantage Plan (HMO, PPO, PFFS)? ☐Yes ☐ No
***Does it cover any medications? ☐ Yes ☐ No

How much have you spent on medications this year? (From January to now):_____

Have you applied for the (LIS) Low Income Subsidy "Extra Help Program" through Social Security? ☐ Yes ☐ No
Were you denied? ☐ Yes ☐ No (if you want more information about this program, please ask our representative)

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Medi-Cal? ☐ No ☐ Yes If yes, does it cover your medications? ☐ Yes ☐ No
Do you have a share of cost? Yes No If Yes how much per month: _____
Have you ever applied for Medi-Cal? ☐ No ☐ Yes Is your application pending or denied?

Are you a veteran of the U.S. Armed Forces? ☐ Yes ☐ No Are you or eligible for V.A. benefits? ☐ Yes ☐ No

***Other services APA refers to or provides:***

Would you like more information about nutrition, yoga, or Zumba classes? ☐Yes ☐No

If you are Diabetic would you like to be enrolled in our Diabetes Care Program or other low cost Diabetes care supplies program? ☐Yes ☐No ☐Not needed at this time

Are you in need of other community resources such as food or shelter? ☐Yes ☐No

Do you resist or put off your doctor's regular annual exams or 3 month checkups because of the cost? ☐Yes ☐No

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**List all of your Current Medications: (List your top three medications your in need of first)**

**1. Drug name: _____dosage: _____**

**Prescribed by doctor: _____used to treat: _____**

**2 .Drug name: _____dosage: _____**

**Prescribed by doctor: _____used to treat: _____**

**3. Drug name: _____dosage: _____**

**Prescribed by doctor: _____used to treat: _____**

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____
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Prescribed by doctor: _____used to treat: _____

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Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____
Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

Drug name: _____dosage: _____
Prescribed by doctor: _____used to treat: _____

List all of your Health Illnesses/Diagnosis:

_____

_____

Allergies ☐ No ☐Yes If yes, Please list:

_____

What pharmacy do you prefer? _____

List any over the counter medications or supplements:_____

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## *Patient Acknowledgement*
## READ BEFORE SIGNING

*In consideration for accepting services performed by Alliance for Pharmaceutical Access, I acknowledge:*

1. I permit the Alliance for Pharmaceutical Access to render services on my behalf for the acquisition for prescribed medications.

2. I understand that the Alliance for Pharmaceutical Access only facilitate the application process. I understand that the Alliance for Pharmaceutical Access is neither a pharmacy/pharmacist nor physician. I further understand that I must take my medications directed by my physician. I will consult my physician or pharmacist with any questions I may have regarding my medical condition, medications, or prescription drugs.

3. I also understand there are potential risks of which I may not presently be aware.

## *Waiver of Liability and Indemnification*

*In consideration for accepting services performed by Alliance for Pharmaceutical Access, on behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I forever:*

Waive, release and discharge Alliance for Pharmaceutical Access and its agencies, officers and employees from any and all negligence and liability for my death, disability and personal injury, property damages, property theft or claims of any nature which may hereafter accrue to me, and my estate as a direct or indirect result of services rendered by the Alliance for Pharmaceutical Access.

Indemnify, save, and hold harmless Alliance for Pharmaceutical Access and its agencies, officers, and employees of, from and against any and all claims of any nature including cost, expenses, and fees arising out of resulting from services rendered by the Alliance for Pharmaceutical Access, Inc.

I, the undersigned, affirm that I am at least 18 years of age and am freely signing this agreement. I have read this form and fully understand that by signing this form I am giving up legal rights and/or remedies which may otherwise be available to me regarding losses I may sustain as a result of services rendered to me. I have had the opportunity to review this from both here and outside of the presence of the Alliance for Pharmaceutical Access and choose to sign of my own free will. I agree that if any portion is held invalid, the remainder will continue in full legal force and effect.

Patient Signature:_____ Date: _____

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Authorized Representative's Name (print name)_____

(Relationship): _____Phone Number:_____

Authorized Representative's Signature: _____Date: _____

Revised 5/2017 CL

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**ALLIANCE FOR PHARMACEUTICAL ACCESS, INC. (APA) HIPAA AUTHORIZATION FORM**

| | |
|---|---|
| **Patient's Full Name** | **Social Security Number** |
| **Address** | **Date of Birth** |
| **City/State/Zip Code** | **Telephone Number** |

I hereby authorize use or disclosure of protected health information about me as described below.
The following specific person/s or facility staff is authorized to use or disclose information about me:

**Alliance for Pharmaceutical Access, Inc. (APA)** (Program Director and Health Advocates)

The following person/s or facility staff may receive disclosure of protected health information about me:

**Alliance for Pharmaceutical Access, Inc. (APA)** (Program Director and Health Advocates)

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**Office Location Sites: 506 East Plaza Drive #5, Santa Maria, CA 93458 / Telephone Number (805) 614-2040**

**Lompoc: 1515 E. Ocean Ave, Lompoc, CA 93436 Telephone Number (805) 737-5799**

**Santa Luis Obispo: 1428 Phillips Lane, Suite B-5, San Luis Obispo, CA 93401 Telephone Number (805) 548-0894**

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The specific information that should be disclosed is:

This authorization will give Alliance for Pharmaceutical Access, Inc (APA) Program Director and Health Advocates the ability to communicate on your behalf with any pharmaceutical company, business, organization, and/or individual in order to verify enrollment status for the Patient Assistance Programs and/or checking on your medication re-order status.

By signing this form, you are giving authorization to Alliance for Pharmaceutical Access, Inc. (APA) to use your personal information in facilitating and completing your patient assistance application/s

_____ _____

**Patient's Signature** **Date**

Authorized Representative's Name (print name)_____

(Relationship): _____Phone Number:_____

Authorized Representative's Signature: _____Date: _____

***Office Use Only** ********** **Office Use Only** ********** **Office Use Only***

## Assessment Worksheet for APA-Advocates

*Mailed or faxed available meds, office location, & instruction information on date: _____*
*Called Patient to give them information or ask them to pick up information on date: _____*

**Advocate Name: _____Assessment Date:_____**

***Uninsured & Insured Clients Information*** *Ready for Processing/ information: (check List) Mark with ☑ (all that apply)*

Signed Waiver and HIPPA Forms_____ Prescriptions _____ Proof of Income _____
Copy of California or other state Identification or license card _____
Copy of Insurance Card/s (front and back) if applicable_____

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Current FPL%_____
Monthly Household Income:_____ Annual Income_____

CDBG FORM (if applicable)_____ CDBG Eligible ☐ EL ☐VL ☐Low ☐Mod Low
CDBG Form Completed date: _____initials:_____
Registered or updated Information onto (Rx Assist Plus) Init. _____ / Input med list into (Rx Assist Plus) Init. ____

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***Further research of other meds done after initial contact and gave list of all available PAP's*** □ Init. ____

***Referred to other resources such as*:** ***Always give United Way Coast2CoastRX Card*** Free Clinics/CHC □
Food/Shelter □ Nutrition Classes □ Yoga/Exercise Class □ Citizenship Education □
Gave coupon, trial offer info, savings or discount card □ Signed up for DCP □ □

Other Resource Referral/s:

_____
Notes:_____
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***Medicare Clients Information:*** *Ready for Processing/ information: (check List) Mark with ☑ (all that apply)*

*If the applicant is married, please collect spouse's income information and total money spent on prescriptions - (PAP's calculate both incomes and expenditures)*

Social Security, Annuity, or Pension Statements _____ or 1st page of Federal Tax Return _____
Copy of Insurance Card/s (front and back)_____ LIS Denial letter _____
EOB from Insurance Company or Pharmacy YTD Printouts _____ Verified Donut Hole/Coverage Gap _____
Prescriptions _____ Copy ID or License Card _____

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***Further research of other meds done after initial contact and gave list of all available PAP's*** □ Init. ____

***Referred to other resources such as*:** ***Always give BetterRX Card*** Gave coupon, trial offer info, savings or discount card □

HICAP □ Social Security LIS Program □ Food distribution centers □

Other Resource Referral/s:

_____
Notes:_____
_____

**Mid-year review of intake: Date____/____/_____ Initials:_____**