Prescription Assistance Program

8 Prospect Street PO Box 2014
Nashua, NH 03061-2014

The Prescription Assistance Program helps patients who have low income and no prescription insurance get certain name-brand, long-term medications through the drug companies **AND THE PRESCRIBING PHYSICIAN is affiliated with Southern New Hampshire Medical Center or St. Joseph Hospital.** If your prescribing physician is located at Harbor Clinic, Greater Nashua Mental Health, Dartmouth-Hitchcock or Lamprey Clinic, please contact one of those agencies for assistance.

This packet includes:

1. An application form
2. HIPAA/signature form
3. 4506T form (Non filing of taxes form)

The following is a checklist required for Prescription Assistance:

Application

- ☐ Completed patient application.
  Applications will be returned if any areas are left blank.
- ☐ Signed HIPAA/signature consent form.

Income Tax Information

- ☐ Copy of your most recent Federal Income Tax Return and all schedules. If you did not file taxes, sign and date the 4506T form.
- ☐ Last year's W2 forms (if you were employed last year).

MONTHLY income for all household members. Possible forms include:

- ☐ Copies of four most recent paycheck stubs or statement from employer.
- ☐ Unemployment or disability benefits statement.
- ☐ Social Security **MONTHLY** Benefit Statement (which include SS, SSDI, or SSI) ☐ Pension benefits statement.
- ☐ Alimony and/or child support.

If you have no income, you need to show that you have applied for public assistance or that you are receiving financial support from a family member.

- ☐ Include copy of notices of approval or denial for public assistance. ☐ Letter of financial support from family member.

**** Do not send bank statements.***

Your application is not complete until we receive all of this information. You should receive notification from the drug companies in approximately six weeks after they receive your application. If anything is missing from your application you will be notified by mail with a list of documents required. We look forward to helping you with your medication needs.

Sincerely,

Prescription Assistance Program Coordinator

Prescription Assistance Program
Patient Application

Your prescribing physician must be affiliated with Southern New Hampshire Medical Center or St. Joseph Hospital. If your prescribing physician is located at Harbor Clinic, Greater Nashua Mental Health, Dartmouth-Hitchcock or Lamprey Clinic, please contact one of those agencies for assistance.

Name: _____ Phone#: _____ SS#:_____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ ☐ Female ☐ Male US Citizen: ☐ YES ☐ NO

Total Household **MONTHLY** Income: $_____ Source of Income: _____

Number in Household: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

File Federal Tax Return: ☐ YES ☐ NO Veteran: ☐ YES ☐ NO

Prescription Coverage Plan: ☐ YES ☐ NO Company:_____

If disabled more than two years: ☐ YES ☐ NO

☐ YES ☐ NO Medicare: If yes, please enclose a copy of your Medicare Card

Medicaid: ☐ YES ☐ NO Spend down:
☐ YES ☐ NO Spenddown Amount: _____

I certify that the above information is accurate and that **I do not** have prescription insurance and cannot afford to pay for my prescription medications.

Patient Signature: _____ **Date**: _____

Medication Allergies: _____

Physician Name: _____ Hospital: ☐ SNH ☐ SJH ☐

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH/DOSE	PRESCRIBING PHYSICIAN

Prescription Assistance Program

Authorization to Disclose Protected Health Information / Signature Consent

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

I authorize the Prescription Assistance Program to use, disclose, or release my protected health information (medical records, financial information) for the purpose of helping me obtain assistance for my prescription drug expenses with any participating pharmaceutical company.

__X__ I authorize the Prescription Assistance Program to submit/exchange personal information, financial information/documentation, insurance information and medical information to pharmaceutical manufacturing companies for the direct benefit of receiving medications under their prescription assistance programs.

__X__ I authorize the Prescription Assistance Program to act as my representative, including signing applications and correspondence in my name, for the direct benefit of receiving prescription assistance.

__X__ I authorize the Prescription Assistance Program to discuss my application and/or case with the following individuals:

_____, _____,

_____, _____

The following information will be submitted to/received by any Person or Entity to which the Prescription Assistance Program may apply to on behalf for the direct benefit of receiving medications as part of the program. **This includes: personal information, medical information, financial documentation, medical insurance information, and medical diagnosis and medication allergies.**

I understand that:

- I may inspect or copy the protected health information described in this authorization.
- This authorization may be revoked in writing and delivered to the Prescription Assistance Program at any time. By doing so, I understand I will no longer be eligible to participate in the program except that SNHMC may complete any actions it initiated in reliance on this authorization and prior to my revocation.
- Information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- By authorizing this release of my medical records I also release the Prescription Assistance Program from all legal responsibility or liability that may arise from the release of these medical records.

DATE _____ _____

Signature of patient or representative

Authority of representative (parent of minor, guardian, etc.) _____

EXPIRATION: This authorization will expire at the end of my participation in the Prescription Assistance Program.