



ENROLLMENT FORM

Are you in a Prescription Plan (select one)? No Yes

Are you in the Epic Program (select one)? No Yes

Name: _____
(Please Print Clearly) Last First

Address: _____
No. Street Apt.# City State Zip code

Telephone Number: ____ - ____ - _____ (To call you when the medication arrives)

Other Telephone Numbers

Cellular #: ____ - ____ - _____ Family/Friend's #: ____ - ____ - _____

Date of Birth: _____ Social Security Number: ____ - ____ - ____
Month/ Day/ Year

Marital Status (select one): single married divorced separated widowed

Sex (select one): male female

Household Size: _____ Primary Insurance: _____

Source of Income: Wage Support by Family Alimony Pension
Social Security Retirement Social Security Disability None
Other: _____

Monthly Household Income: \$ _____

Are you a veteran? No Yes Are you disabled? No Yes

Ethnic origin (select one): African-American Asian Native American
Hispanic White Other

Any known allergies: _____ Chronic condition: _____

Name of Physician: _____

Please initial over the appropriate box: (These are not conditions for participation)

I permit my Provider to discuss any improvement of my health status as a result of my participation in this program.

I agree to participate in surveys regarding my experience with the Pharmacy Assistance Program conducted by Ambulatory Care Network Community Health Outreach.

****All information will be used solely for the purpose of improving the quality of the Pharmacy Assistance Program****

Date

ACN-PAP can only process prescriptions written by physicians on NYPH's medical staff



I, _____ consent to be enrolled in the Pharmacy Assistance
(Print Full Name)

Program. I fully understand the nature of the Pharmacy Assistance Program and will adhere to the Patients' Enrollment Guidelines that I was given.

By signing this consent I authorize ACN-PAP staff to share with the pharmaceutical manufacturers the information I provided on this form for the sole purpose of obtaining my medication through their Patient Assistance Program. I am aware that in the case that medications that are ordered for me through ACN-PAP are not collected within 90 days of being received by the participating pharmacy, ACN-PAP is not responsible for the distribution of said medications. In such a case, a new application must be generated.

I also understand that ACN-PAP requires proof of income or a statement of benefits to provide verification for eligibility and by signing this consent I give permission to ACN-PAP to obtain this proof of income or statement of benefits from my health care provider or community health facility.

Furthermore I authorize the coordinator for the ACN-PAP program to sign and date all documentation/forms that are sent to any of the participating pharmaceutical companies on my behalf. The role of ACN-PAP shall be limited to administrative functions and signatory power in reference to eligibility forms that are submitted to the participating pharmaceutical companies for prescription medication.

I understand that by signing this consent form does not automatically qualify me to receive prescription medications from the participating pharmaceutical companies, which have their own guidelines.

(Patient Signature)

Date

PLEASE BE SURE TO INCLUDE

1. An original prescription for the brand name medication
2. Proof of income
3. Copy of Medicare card (if applicable)

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Patient Responsibilities

- * *Must **fully** complete application*
- * *Request **original** prescriptions from physician*
- * *Copy of Medicare Card (if applicable)*
- * *Provide proof of income:*
 - *Social Security Statement, Pension, Worker's Comp.*
 - Or*
 - *Bi-weekly pay (2 pay stubs), weekly pay (3 or 4 pay stubs)*
 - Or*
 - *Award letters*
 - Or*
 - *Support letter*

- * *If you do not have proof of income, please obtain any of the documents listed above from the individual who is supporting you.*

- * *When you only have **30 days** of your medications, you should contact your physician or social worker and request **two** new original prescriptions, one will be sent to ACN-PAP and the other one will be sent to you. ACN-PAP **must** order patients' refills; **the pharmacy cannot fill refill request.***

PLEASE GIVE THIS DOCUMENT TO THE PATIENT, THANK YOU.