Medication Access Program—Patient Agreement and Authorization

Patient Name (first, middle initial, last):_____

Date of Birth (mm/dd/yyyy):_____

I certify that the information reported to the Medication Access Program is accurate and complete to the best of my knowledge.

I agree to notify the Medication Access Program of any changes that may affect my eligibility in the program.

I agree to notify the Medication Access Program of any changes in my medications (i.e., discontinuance of prescription medication, starting new prescription medication, dosage or frequency of taking prescribed medication.)

I authorize the Medication Access Program Staff to:

Use and disclose the information reported by me to assess my eligibility for participation in pharmaceutical patient assistance programs

Pursue refills on any medication prescribed to me by my physician.

Use and disclose my protected health information, as necessary, to facilitate the healthcare operations of the Medication Access Program.

I further understand this is a legal document.

_____ _____

Signature of Patient
or Person Authorized to Sign on Behalf of Patient

Date

_____

Screener Signature

Eligibility Information

803 Lynn Street • Cadillac MI 49601 • 231-876-6151

First Name:_____ MI:____ Last Name:_____

Date of Birth: _____/_____/_____ Male _____ Female_____ Social Security Number_____-_____-_____

Address: _____ City: _____ Zip: _____

County: _____ Email: _____

Home Phone: _____ Cellphone: _____

Employer: _____Temp Agency_____

Employment Status: Full-time Part-time Seasonal Self-Employed Unemployed Retired Disabled

Number of people in household: Adults (18 & over)_____ Children:_____

Marital Status: Single Married Divorced Widowed Partner

Housing: Own Rent Stay with friend/family Shelter

United States Veteran: Yes_____ No_____ **Citizen of United States:** Yes_____ No_____

Race/Ethnicity: White Black Hispanic/Latino Asian/Pacific Islander Native American Other

Primary Language: English Spanish Other Interpreter Needed

Highest Education Level: _____

How did you hear about the Medication Access Program?

_____

Who is your primary care provider? _____

Health insurance coverage: Yes_____ No_____

Emergency Contact Person: _____ Relationship:_____

Emergency Contact Phone Number: _____

I also understand it is my responsibility to inform staff of any changes. I authorize the Medication Access Program to process my Eligibility Information and to share this information with charitable organizations to determine benefits.

Patient Signature: **Date:** **Screener Signature:** **Date:**

1._____ **1._____**

Name (First, Middle Initial, Last):_____ Date of Birth: ____/____/____

Medical History (Check all that apply):

AIDS/HIV		Diverticulosis		Nervousness	
Alcoholism		Dizziness/Fainting		Numbness/Tingling	
Allergies		Hearing Aids		Osteoarthritis	
Anemia		Eye Disease		Osteoporosis	
Anxiety		Glasses/Contacts		Polio	
Arthritis		Frequent Infections		Peptic Ulcer Disease	
Asthma/Wheezing		Gallbladder Disease		Pneumonia (chronic)	
Bowel Irregularity		Gout		Rashes	
Bronchitis/Chronic Cough		Headaches (chronic)		Recovering Addict	
Bruise Easily		Heartburn		Rheumatic Fever	
Cancer		Heart Disease		Scarlet Fever	
Chronic Pain		Hepatitis B		Seizure Disclosure	
COPD		Hepatitis C		Sexually Transmitted Disease	
Crohn's Disease/Colitis		Hernia		Stomach Ulcer	
Coronary Artery Disease		Herpes		Strokes/TIA	
Dental Problems		High Blood Pressure		Thyroid Disease	
Depression		High Cholesterol		Vein Disease	
Diabetes—Type 1		Kidney Stones		Weight Gain or Loss (recent)	
Diabetes—Type 2		Mental Illness		Tobacco Use	
Difficulty Swallowing		Migraine Headaches		Other:_____	

Do you have medication allergies? Yes____ No____ **If yes, please list allergies:** **_____**

_____

Please list all your prescription and over-the-counter medications:_____

Patient Signature: **Date:** **Screener:** **Date:**

1. _____ _____

Name (First, Middle Initial, Last):_____ Date of Birth:____/____/_____

Consent to Share Confidential Medical Information

I HEREBY AUTHORIZE MEDICATION ACCESS PROGRAM TO SHARE (check all that apply):

____Any of my medical information ____My appointment times, dates, and reasons for the visits

____My lab results X__ The medications I am taking

WITH THE FOLLOWING PEOPLE

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

Full Name:_____ Relationship:_____

I understand that I may cancel this consent at any time (by writing to Medication Access Program), but that canceling it will not affect any information that has already been released.

Notice to Patients

Medication Access Program Recipients:

- When your primary care physician makes a change to your prescription medication, you need to let us know as soon as possible.
- Prescription medication refill requires 30-day advance notice.
- Eligibility process is completed annually. Required documentation for re-eligibility includes:
  - Proof of income (previous year's tax return, or one month of paycheck stubs.)
  - Copy of Driver License or State of Michigan identification card.

The information given is correct to the best of my knowledge. I understand my information will be held in the strictest of confidence, and it is my responsibility to inform the Medication Access Program of any changes in my medical status and contact information.

_____ _____

Signature of Patient Date

Screener Signature_____