Delta Community Action
Foundation, Inc.
Prescription Assistance Program
308 S.W. 2nd Street Lindsay, OK 73052
Phone: (405) 756-1100 Fax (405) 756-1104
www.deltacommunityaction.org

Patient Assistance Contract

Dear Client/Patient, **read each item before signing below:**

The Prescription Assistance Program was created to ease the burden for low-income, uninsured patients, who cannot afford their prescription medications. This program is offered through Pharmaceutical companies. In order to complete the process you will be required to fill an application and provide us with financial documentation. You will be required to complete an application and supply financial documentation to us in order to complete the process. We ask that you do your part in supplying the necessary documentation required.

A. Complete the attached application in its entirety. Leaving questions blank may lengthen the application process.
B. You **MUST** provide a copy of the following items:
    1. Income taxes from the previous year
    2. Proof of current income for, (3) three months Pay Stubs, Unemployment Compensation, Social Security Award Letter, Social Security Disability Letter, Child Support, Alimony Support, Food Stamp Award Letter, Medicaid (SoonerCare) Medical Denial Letter, or any other income
    3. Current Health/Prescription Insurance cards if any

C. Notify our office if your financial or insurance situation changes.

We ask that you read this document carefully and sign it if you understand and agree to comply with these requirements. If you have any questions about them, please do not hesitate to ask.

Thank you for your understanding.

_____ _____

Patient Signature Date

Delta Community Action Foundation, Inc.

ALLERGY AND HEALTH CONDITION INFORMATION:

ALLERGIES:

None:	Y:	N:
Codeine:	Y:	N:
Sulfa:	Y:	N:
Penicillin:	Y:	N:
Tetracycline:	Y:	N:
Iodine:	Y:	N:
Aspirin:	Y:	N:

Other (list): _____

_____

HEALTH CONDITIONS:

Diabetes:	Y:	N:
Heart:	Y:	N:
Stomach:	Y:	N:
Thyroid:	Y:	N:
Arthritis:	Y:	N:
Asthma:	Y:	N:
COPD:	Y:	N:
Migraines:	Y:	N:
Cholesterol:	Y:	N:
Depression:	Y:	N:
Hypertension (^BP):	Y:	N:
None:	Y:	N:

Other (list): _____

_____

Other Comments:

_____

_____

_____

Delta Community Action Foundation, Inc.
Rx for Oklahoma Application for Services

Date: _____

Patient Name: _____
First Middle Last

Address: _____
Street City State Zip

Date of Birth: ___/___/____ Current Age: _____ Male: Female:

Employer/Occupation: _____ SSN: _____-_____-_____

_____ _____ _____
Home Phone Cell Phone Work Phone

Race: Caucasian African American Hispanic Asian Native American Other

Marital Status: Single Married Divorced Widowed Education Level: _____

U.S. Citizen? Y N U.S. Resident? Y N

How many adults, including yourself, live in your home? _____ How many children? _____
Housing: Own Rent OCHA/Sect. 8 Family/Friends Other _____

Please indicate below the programs which apply to the patient:

Program	Yes	No	Applied	Pending
Medicaid (SoonerCare)				
Medicare				
Indian Health Services				
Veteran's Health Benefits				
Health Insurance (any Kind)				
SNAP (Food Stamps)/ WIC				
TANF				
Legally Disabled				

Employment Status: Full Part Retired Unemployed Self-Employed
Total **ANNUAL** Household Income (wages &/or assistance):
Below $25,000 $25,000-$35,000 $35,001-$45,000 $45,001-$55,000

NOTE: *Proof of Income/Expenses* may be requested at ANY time by *Rx for Oklahoma* or through outside resources working with the program to provide you with necessary assistance.

Wages:$_____ Unemployment:$_____ SSI/SSD:$_____ Retirement:$_____
Alimony/Child Support:$_____ Veterans Benefit:$_____ Other:$_____
Total MONTHLY Household Income: $ _____
File Taxes for PREVIOUS YEAR? Y N

Delta Community Action Foundation, Inc.

PATIENT CONSENT AND RELEASE FORM

The Prescription Assistance Services, Rx for Oklahoma, is designed to address the medication needs of individuals in our community. This program participates with pharmaceutical manufactures to offer assistance and provide medications to low-income, uninsured, and under insured people. These medications will be free or discounted for those that qualify. These medication manufactures often require personal demographic, therapeutic, and financial information as part of the application process. For your convenience, we are requesting your permission to access and provide the manufactures with the requested medical and financial information.

By signing this statement, you authorize the Prescription Assistance Service to complete all forms and applications on your behalf, and to access and release any personal demographic, therapeutic, and/or financial information relating to applications for drug manufacturer assistance programs. This includes signing your name on your behalf.

You further authorize the Prescription Assistance Service, Rx for Oklahoma, to discuss your medical needs, medications, and any other related information with your physicians, or their staff.

You further authorize the Prescription Assistance Service, Rx for Oklahoma, to act as an Advocate on your behalf in order to assist you in obtaining your medications, or complete applications.

This authorization may be revoked at any time by contacting the Prescription Assistance Service, Rx for Oklahoma at (405) _____. The individual signing this document reserves the right to appeal any decision made regarding assistance provided by Rx for Oklahoma and participating partners. The right to appeal does not guarantee the right to modify individual pharmaceutical company policies and procedures. I have read and understand this agreement. I voluntarily sign my consent. I understand I have the right to appeal any decision I do not agree with. I understand that a copy of the policy is available to me upon request.

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Print Name of Patient: _____ Date: _____

Signature: _____

****Administrative Use Only****

Print Name of Advocate: _____ Date: _____

Signature: _____

Address and Telephone Number of the CAA office/center or Partnering Clinic where this statement was signed

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(Facility Name) (Address) (Phone)

community Action PARTNERSHIP
Helping People. Changing Lives.

Rx FOR OKLAHOMA

Delta Community Action Foundation, Inc.

Information About Your Medications

Please list all medications that your are prescribed				
Name of Medication:	Dosage (i.e. twice daily)	Strength (i.e. 50mg, 25units)	Condition(s):	Physician:

Delta Community Action Foundation, Inc.

New Client Questionnaire: Date: ____/____/_____

1. Age: 0-20 21-40 41-64 65-80 older than 81

2. Gender: Male Female

3. How many adults, including yourself, live in your home? _____ How many children? _____

4. Approximately, how much do you spend EACH MONTH on your medications?

$0-$50	$51-$100	$101-$150
$151-$200	$201-$250	MORE THAN $250

5. How have you been obtaining your medications? (*Mark all that apply*)

Family/Friend	Paying Cash	Free Clinic	$4 Meds
Samples/Doctor	County Pharmacy	Go Without	

Other (Please Specify):_____

6. How did you hear about the program?

Action Agency	Community Clinic	DHS	Doctor office
Employee	Family/Friend	Flyers/Brochures	Hospital
Website/Internet	Word of Mouth	Other: _____	

Form **4506-T**
(Rev. September 2015)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip. Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

Caution: If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ _____

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2011, filed in 2012, will likely not be available from the IRS until 2013. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

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Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** For transcripts being sent to a third party, this form must be received within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ _____ _____
Signature (see instructions) Date

▶ _____
Title (if line 1a above is a corporation, partnership, estate, or trust)

▶ _____ _____
Spouse's signature Date