WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

MEDICATION BRIDGE ASSISTANCE PROGRAM

Dear Patient:

Thank you for your interest in the Medication Bridge Program (MedBridge). The goal of this program is to assist eligible uninsured and underinsured patients of White Mountain Community Health Center to receive needed prescription medications from pharmaceutical companies that offer assistance programs. The price for each 90-day supply of medication through our program is $6.00 per prescription and is based on final eligibility in the program.

Please complete the attached application and return it by mail or drop it off at the health center, with current proof of your income.

Proof of income could be any or all of the following, depending on your situation and the pharmaceutical company applied to:

1. Most recent tax return, first 2 pages only
2. Current paystubs, last 4 weeks, consecutive
3. Unemployment Benefits Statement
4. Child Support or Alimony
5. Social Security Award Letter for current year
6. VA Benefit Statement

If none of the above pertains to your situation, you must speak with an advocate at the health center in the Medication Bridge program in order for them to advise you of what documentation would be acceptable.

Once we receive your completed New Patient Application, Information Release Consent Form and proof of income, we will begin processing your application to the pharmaceutical companies. Please remember, it may take 4-6 weeks before the first shipment of medications arrive in our office.

The co-pay for each 90-day supply is currently $6.00.

If you should need further assistance in filling out this application, or have any questions, please feel free to call us at (603) 447-8900 ext. 302.

Sincerely,

Krystal Brown
Medication Bridge Coordinator

Medication Bridge Application
Please fill out this application. Incomplete applications cannot be processed.
If you need help, please call the MedBridge Coordinator at (603) 447-8900 ext. 302.

Name:_____
First Middle Last
Address:_____
Street City State Zip Code
Phone: ( )_____-_____ Cell: ( )_____-_____ Martial Status:_____ US Citizen? _____

Spouse's Name:_____ Household Size:_____ Veteran? _____
Legally Disabled? ____ for more than 2 years? ____ Did you file taxes last year? _____ *(Include a copy of your return with application)*
Have you filed for Medicaid? _____ If yes, have you been denied? _____ *(Include copy of denial letter with application)*
Referred by town agency:_____ Contact Name:_____

Income Information: Please specify weekly (w), monthly (m), yearly (y), & include all residents
Employment: $_____ Unemployment: $_____ Worker's Comp: $_____ Social Security: $_____
Pension/Retirement: $_____ Disability: $_____ Child Support: $_____ Alimony: $_____
Other (specify): $_____ **Total household income for all residents:** $_____

Social Security # _____-_____-_____ Date of Birth ____/____/_____ Allergies:_____

Primary Care Provider Name:_____ ARNP MD
Insurance: None Medicare Medicaid Anthem United Health Harvard Pilgrim Other_____
Do you have prescription coverage with your health insurance? Y or N

How did you hear about this program? _____

Authorization to Disclose Protected Health Information/Signature Consent

Patient Name:_____ DOB: _____/_____/_____
This authorization will allow White Mountain Community Health Center to use/disclose my protected health information for the purpose of receiving medication through pharmaceutical company programs as a participant in White Mountain Community Health Center's MedBridge Patient Assistance Program.

I authorize White Mountain Community Health Center's MedBridge Program to submit/exchange personal information, financial information/documentation, insurance information and medical information for the direct benefit of receiving medications as part of White Mountain Community Health Center's MedBridge Patient Assistance Program
I authorize White Mountain Community Health Center's MedBridge Program to sign applications and correspondence in my name for the direct benefit of receiving medications as a part of White Mountain Community Health Center's MedBridge Patient Assistance Program.

The following information will be submitted to/received by any Person to which White Mountain Community Health Center's MedBridge Patient Assistance Program may apply to on my behalf for the direct benefit of receiving medications as part of White Mountain Community Health Center's MedBridge Patient Assistance Program. This includes: personal information, medical information, financial documentation, medical diagnosis(es) and medical allergies.

I understand that:

- If I authorize disclosure of protected health information, the recipient may further disclose this information and Federal Law will no longer protect it.
- I have the right to inspect or receive a copy of the information I am consenting to release within the established policies of White Mountain Community Health Center.
- I have the right to revoke this authorization at any time, in writing.
- Canceling this authorization will prohibit disclosures of protected health information after the date the cancellation letter is received and processed by White Mountain Community Health Center, but will not affect disclosures made before that time.
- White Mountain Community Health Center will not refuse treatment to me based on my refusal to sign the authorization unless the sole purpose of the request is to create records for disclosure to someone else.

This authorization will expire at the end of my participation in White Mountain Community Health Center's MedBridge Program.

Signature of Patient or Representative:_____ Date:_____

Relation to Patient:_____

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Medication Bridge Patient Assistance Contract

We will try our best to secure free or discounted medications on your behalf; however, each pharmaceutical company has its own policy and financial guidelines that we must follow. Below are a few of the things that we expect from you:

- Provide proof of income. This can be a copy of last year's tax return, a copy of your statement of benefit from Social Security, copies of the last four check stubs, or other documentation that the pharmaceutical company stipulates. Your financial information does not go into your medical chart and will be used only to apply for the programs. Proof of income is required yearly.
- If you are accepted into an assistance program, you will be notified. The medication will come to your provider's office, and you will have to sign for it. Medications usually come with a 90-day supply or less. When you pick up the medication, the cost for the medication will be a co-pay of $6.00, unless prior arrangements are made.
- Notify the office when you are down to a 30-day supply of medication. This will ensure that you receive your refill in a timely manner, since it can take the pharmaceutical company as long as 3-4 weeks to issue a refill. If you do not notify our office within this time frame, you may run out of your medication. We will give you a prescription for your medication, but you will be responsible for the cost of the medicine. If through no fault of your own the medication does not arrive in time, we will issue you free samples (if we have them) until your medication arrives. It will be your responsibility to pick up your medication as soon as possible.
- Notify our office if your financial or insurance situation changes.
- Keep in mind that once a medication has a generic substitute, many pharmaceutical companies will no longer provide assistance for that drug. We will do our best to keep you informed when this happens. Your cost for a generic drug is much cheaper than the brand name form. Over-the-counter medications available at pharmacies are not offered by assistance programs.
- If you are habitually late in contacting the office for refills, completing forms or picking up your medications, or if you abuse your assistance medication, fail to provide the office with required financial information, or fall to schedule and keep appointments with your provider, we will no longer assist you in these programs.

Given the increasing size of our Patient Assistance Program, it has become necessary for us to put these rules into place to ensure that all of our patients receive the same benefits. 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.

By signing this document, I am authorizing the donation to White Mountain Community Health center of unused prescription medications originally obtained for me by an authorized representative of White Mountain Community Health Center through the Medication Bridge Assistance Program. This includes medications that I have not claimed and/or medications that I no longer need as determined by my healthcare provider. I also agree that I have read and understand the expectations of me as a participant in the Medication Bridge Program as they are outlined above.

_____

Patient Name (please print)

_____ _____

Patient Signature Date