WORLD MEDICAL RELIEF

21725 Melrose Ave., Southfield, MI 48075, 313-866-5333, Fax: 313-866-5588
www.worldmedicalrelief.org

Oakland County Affordable Prescriptions Application

For internal use
Date Received _____
Code:_____

PLEASE PRINT CLEARLY

Name:_____ Address: _____

City: _____ State _____Zip: _____ County:_____ Phone: _____
Email: _____ Cell Phone:_____

SSN: ____ - ____ - _____ DOB: _____/____/_____ Marital Status: S___M___ D___ Sep___W____

US Citizen: Yes___ No ___ Male: ___ Female: ___ Disabled: Yes___ No ___ Hd. of Hshd. ___

Employment Status: Retired ___ Unemployed ___Working full time ___ Working part time ___

Emergency contact person _____Contact phone # _____

LIST ALL YOUR PRESCRIPTIONS

MEDICATION	STRENGTH	FREQUENCY (ex: Take once daily)

List any allergies to medications:_____

Do you have any insurance coverage that pays for all or part of your prescription medication: Yes___ No ___
(Private insurance, Medicaid, Medicare supplemental, VA medical benefits, AIDS drug assistance, state or local programs)

Monthly Household Income (If married, include both husband and/or wife)					
Net wages	$	Tax stmt-1040	$	Alimony	$
Soc. Security	$	Pension	$	Food Stamps	$
S.S. Disability	$	Medicaid	$	Other	$
Unemployment	$	Bridge Card	$	Total Income	$

For this application to be approved, you must include documentation of your monthly household income: pay stub, unemployment information, pension information, copy of bridge card, etc.

The above information is correct to the best of my knowledge_____
Signature and date

Please complete all 4 pages of this application and email it to gethelplocal@worldmedicalrelief.org

How did you hear about the Affordable Prescription Program?

Because this organization receives federal funding intended for low and moderate-income households in the City of Detroit, the indicated information is requested for statistical reporting purposes. Racial breakdowns are required for federal reporting purposes. Please check only one of the listed categories.

Hispanic or Latino	
NOT Hispanic or Latino	
White	
Black or African American and White	
Black or African American	
Asian	
Asian and White	
Native Hawaiian or Other Pacific Islander	
American Indian or Alaska Native	
American Indian or Alaska Native and Black African American	
American Indian and White	
***Other multi-racial category: List**	

Don't forget to include proof of your income and a copy of your ID. Make sure you sign and date the application and the Privacy form. Complete the questionnaire to the best of your ability.

On Page 1 – Head of Household means a woman with a child/children under the age of 18.

Are you a diabetic? Yes_____ No _____

Do you use insulin? Yes_____ No _____ Do you take diabetic medication by mouth? Yes_____ No_____

Are you applying to this program for assistance with your diabetic medication? Yes _____ No _____

Would you like further information on diabetes and wellness programming? Yes_____ No_____

WORLD MEDICAL RELIEF™

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that World Medical Relief comply with certain rules regarding maintaining privacy of your medical information that we have collected and will collect in the future. This applies to the information you provided World Medical Relief when you applied for the Affordable Prescription Program as well as information regarding the prescriptions we are receiving and filling for you from your physician.

Existing Michigan law requires us to obtain, or attempt to obtain, your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a court order as part of a criminal investigation; or a licensure investigation.

From time to time it may be necessary for us to make disclosure of your information.

PATIENT ACKNOWLEDGEMENT

Please sign this form below under the heading "acknowledgement" that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

Date_____

PATIENT CONSENT

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with the proper services of the Affordable Prescription Program.

_____ _____

Patient Signature Patient Name (please print)

Date _____

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WORLD MEDICAL RELIEF AFFORDABLE PRESCRIPTION PROGRAM

ENROLLMENT SURVEY

Please answer all questions to the best of your ability. We cannot process your application unless the survey is completed.

1. I spend $_____ per month for my prescription medicines. (Please include the total)

   How often are you able to pay for all of your prescriptions each month? (Circle answer that applies).

   Always Almost Always Sometimes Rarely Never

   If you are not able to pay for all of your prescriptions each month, please complete the following:

   Each month I have $_____ in uncovered prescription cost.

2. How often do you worry about having enough money to buy prescription medication?

   Always Almost Always Sometimes Rarely Never

3. How often do you have to make a choice between buying prescription medication and paying bills?

   Always Almost Always Sometimes Rarely Never

4. Please rate how easy it is to manage your health problems: (Circle the answer that applies)

   Very Easy Somewhat Easy Somewhat Difficult Very Difficult

5. On a scale of 1 to 5, - with one being the lowest – please rate your energy level:

   1 2 3 4 5

6. Please rate how healthy you feel: 1 2 3 4 5

7. Please rate how active you feel: 1 2 3 4 5

8. If I need to go to the drug store, see a doctor or dentist, or participate in other medical appointments, I can get there on my own without help from family or a caregiver.

   Yes ____ No____

9. I usually must rely on family or a caregiver to help me get to my medical appointments or the drug store.

   Yes ____ No ____

NAME_____CITY_____DATE_____

World Medical Relief APP

This page is for internal purposes ONLY. Applicants do not have to write anything on this page.

Client Name:

Notes:

World Medical Relief Administrative Section ONLY: Approved by & Date: