Shannon Medical Center

Pharmaceutical Assistance Program

The Shannon Pharmaceutical Assistance Program (PAP) provides support to patients who are uninsured or who have no coverage in their insurance plan for medications. The program's goal is to provide qualified patients with medications needed at the lowest cost possible to help control chronic conditions so they may avoid future healthcare events and re-admissions.

A completed application and financial documentation is required of each individual seeking assistance. All documentation must be received before we can determine your qualification for the program.

Required documentation includes:

1. Complete Application
2. Copy of Pharmaceutical Assistance Program Guidelines
3. Release of Information
4. List of all current medications
5. Copy of applicant's Driver's License or other identification with a picture and address
6. Copy of applicant's Social Security Card
7. Copy of applicant's current Proof of Income (Please refer to the Income Requirements on page 3. We require a copy of the most recent Social Security Statement and do not accept copies of bank statements.)

Remember: All of the required documents must accompany your application. All individuals residing in the same household must provide proof of income. An incomplete application will be placed "on hold" until all requested documents are provided.

If you have third party coverage such as private insurance with prescription coverage, Medicaid, or Medicare Part D, you are not eligible to apply for the Shannon Pharmaceutical Assistance Program.

Please feel free to contact our office if you have any questions about the application process or qualification guidelines.

Shannon Pharmaceutical Assistance Program
Open: Monday-Thursday
8:00 a.m. to 12:00 p.m.
1:00 p.m. to 4:00 p.m.

325-657-8323
119 E. Beauregard, Suite B
San Angelo, TX 76903

Income Requirements

The following documents are required for income verification
in order to determine qualification for our program:

Salary/Wages and/or Part Times Wages: Complete copy (not just W-2) of most recent Income Tax Return. If you do not file a tax return and are employed, please submit a statement of your gross monthly wages from your employer on their letterhead and/or copies of three months of paystubs. If you are self-employed, please write a letter stating your monthly income. If you did not file a tax return by April 15, please bring a copy of your Extension Approval.

Letter of Support/No Income in the Household/Homeless: If you are receiving financial support from family or friends (not living with you in the same household), please complete this form provided by our office. If you are homeless, without residence, please provide either a letter verifying your status from an area shelter or a notorized statement documenting your living situation.

Social Security, SS Disability, and Supplemental SS: Copy of your most recent Social Security Statement. If you receive SS payment through direct deposit, the local Social Security Office can print this for you. The statement should include the amount you are receiving monthly for the current year. (Note: This is not the statement you receive at the end of the year that looks like a W-2 form.) If you are filing for Disability and have not received benefits yet, we need a copy of your hearing date or copy of your application for Disability benefits.

Approval/Denial for Extra Help with Medicare prescription drug costs: If you have Medicare and you have applied for this Low Income Subsidy assistance through the Social Security office, we require a statement of your approval/denial to file with your application. If you are over 65, this is required by most phamaceutical companies granting assistance. If you have not applied for this benefit, please ask a pharmacy associate or the Social Security Office how to apply.

Retirement: Copy of your most recent Retirement Statement, listing your monthly income.

Veteran's Assistance: Copy of your most recent Pension Statement stating your monthly benefit. If you are the patient receiving VA benefits, you most likely will not qualify for the Pharmaceutical Assistance Program, since the VA clinic fills prescriptions for you at a minimal cost. If a medication is not covered by the VA, we need documentation stating that the medication is not covered.

Child Support/Alimony: Copy of most recent statement from the Texas Attorney General's Office.

HUD Assistance: Copy of Letter Of Verification from the HUD Office stating your monthly rent/mortgage payment and monthly HUD contribution.

Food Stamp/TANF-Public Assistance: Copy of most recent Statement from the Texas Dept. of Health and Human Services Office stating monthly assistance for food and TANF.

Worker's Compensation: Copy of most recent Statement from Workers Comp. stating injury, date of injury and any company responsibility to pay medications or medical bills from that particular injury.

Unemployment Benefits: Copy of most recent Statement from Unemployment Office stating monthly benefit and length of time this will be received.

Please remember: Patients are required to notify the PAP Staff of any changes in income or insurance status.
The PAP requires income documentation for each person in the household. Copies of bank statements are not accepted.

Shannon Business Services, Inc.
Pharmaceutical Assistance Program

Authorization for Release of Information

Release information from the Pharmacy Assistance Program record of:

Patient Name:____ Date of Birth:______________

Social Security No.________________________ Phone Number(s)______________________________

I authorize Shannon Business Services, Inc. Pharmaceutical Assistance Program to release required information to any drug company to ensure my application for manufacturer's assistance programs is completed.The purpose of this disclosure is to secure assistance in providing medications to low-income patients.

The information to be released is contained in the records maintained by the Pharmaceutical Assistance Program. I understand specific information to be released may include history of drug, alcohol or mental health treatment or information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and laboratory test results, treatment progress or any other such related information.

Further, I authorize Shannon Business Services, Inc. Pharmaceutical Assistance Program to discuss my prescriptions and/or medical records with the individuals specified below.

____ ____

____ ____

____ ____

I understand I may revoke this authorization at any time to the extent that action has been taken in reliance on it. The authorization will expire one year from the date of my signature or as otherwise specified below.

____ ______________________________

Signature of Patient or Legal Representative Relationship

____

Date

This information has been disclosed to you from records protected by Federal Confidentially Rules (42CFR, Part 2). The federal Rules prohibit you from making any further disclosure unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR part 2. A general authorization for the release of medical or other information not sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Shannon Medical Center
Pharmaceutical Assistance Program

Pharmaceutical Assistance Program Guidelines

1. The entire Application (intake form) must be completed before we can assist you with any medications.

2. Prescriptions are required for all medications. Your doctor may call or fax a prescription, or you may bring a written prescription with you when you order your medications. If you do not have a current prescription, or available refills, you will not be able to pick up the medication.

3. We will only be responsible for ordering the medication as listed on your intake form. It is your responsbility to ensure the information on your intake form is correct. You must notify PAP staff of changes to income, household size, or insurance status.

4. You must call the PAP Pharmacy to reorder your medication(s). You should call for refills 7 days prior to running out of medication. If you do not call in advance to refill your prescription, we may not have your medication available or you may have to buy the medication from a retail pharmacy at full price. The PAP Pharmacy phone number is (325) 657-8323.

5. The Pharmaceutical Assistance Program hours are Monday through Thursday from 8 a.m. to Noon and 1 p.m. to 4 p.m.

6. We are only able to provide service to eligible patients and those patients who are compliant with the program guidelines. Your cooperation is appreciated. Please be considerate and respectful of other patients and PAP employees.

7. Shannon Pharmaceutical Assistance Program will charge an administrative fee in addition to the cost of the medication.

8. Please contact the PAP with any questions, complaints, or concerns so we may better serve you. Shannon Pharmacy is not associated with this program and cannot assist with these matters.

I have read and agree to abide by the Guidelines of the Shannon Pharmaceutical Program. Following these guidelines is important to maintaining program eligibility and ensuring I am able to receive approved medications on a timely basis.

____________________________________ ____________________

Signature of Patient or Legal Representative
(Please provide a copy of your Power of Attorney)

Date

____________________________________ ____________________

Patient's Name

Date of Birth

Doc. No 2104339.2 09/13

Intake Application

Doc. No. 2104248A.3

The entire Intake (application) must be completed before we can help you with any medications.

Date:________________________

Social Security #_______________________________ Driver's License No.__________________________

Tom Green County Indigent Applicant # ______________________

Last Name__________________________ First Name____________________________ MI______ M / F

Home & Mailing Address____________________________________ City__________________________

State______________ Zip Code__________________ County___________________________________

Day Phone #________________________ Cell Phone # ________________________

Patient DOB_____/_____/______ Race (Optional)___________ US Resident? Yes No

Marital Status (circle one) Married Divorce Separated Widowed Single
Spouse Social Secuirty # _______________________________

Work Status (circle one) Employed Unemployed Disabled Retired Laid Off

Employer____ Job Title:__________________________
Do you have the same employer as listed on your tax return? Yes No

Spouse's Employer____________________________________ Job Title____________________________
Do you have the same employer as listed on your tax return? Yes No

MEDICAL

Do you have MEDICAID? YES___ NO___
Do you have MEDICARE? YES___ NO___
Have you applied for the Low Income
Subsidy Extra Help? YES___ NO___
Do you have private insurance? YES___ NO___
Do you have Veteran's benefits? YES___ NO___

PRESCRIPTION

Any Meds on MEDICAID? YES___ NO___
Any Meds on MEDICARE? YES___ NO___
Any Prescription coverage? YES___ NO___
Are you legally disabled? YES___ NO___
QMB MEDICAID? YES___ NO___
MEDICARE Part D? YES___ NO___

List all persons living in the house

NAME	RELATIONSHIP	DATE OF BIRTH	EMPLOYED	UNEMPLOYED

Medication Allergies: ____

Shannon Medical Center

Doc. No. 2104248C.4 11/10 Pharmaceutical Assistance Program

PLEASE ENTER YOUR MONTHLY INCOME AND EXPENSES IN SPACES BELOW
PLEASE INCLUDE AMOUNTS FOR ALL PERSONS LIVING IN THIS RESIDENCE
PATIENT WILL SUPPLY PROOF OF INCOME FOR EACH ITEM IN THE INCOME SECTION

MONTHLY INCOME

SALARY/WAGES ______
ALIMONY ______
CHILD SUPPORT (Received) ______
TANF ______
HUD ______
FOOD STAMPS ______

SS INCOME ______
SS DISABILITY ______
WORKERS COMP. ______
UNEMPLOYMENT ______
RETIREMENT ______
VA/PENSION ______
RENTAL INCOME ______

ASSETS

CHECKING BAL ______
SAVINGS BAL ______
REAL ESTATE ______
(Other than where you live)
CARS (MODEL/YR) ______
STOCKS/BONDS/IRA'S ______
OTHER ______

MONTHLY LIVING EXPENSES

MORTGAGE ______
RENT ______
UTILITIES ______
GAS FOR CAR ______

HOME OWNERS INS ______
AUTOMOBILE INS ______
CHILD CARE ______
CHILD SUPPORT (Payment) ______

PROPERTY TAXES ______
CABLE/SATELLITE ______
PHONE/CELL PHONE ______
OTHER EXPENSES ______

MONTHLY MEDICAL EXPENSES

MEDICAL FEES ______
DOCTOR FEES ______

PRESCRIPTIONS ______
DENTAL ______

VISION ______

Contact Person, other than house members ______

Relationship ______ Phone# ______

Shannon Medical Center in furtherance of the mission to provide healthcare, is participating in a program with drug manufacturer's, which offer assistance in providing medications to low-income/non-insured patients who meet certain standards. The drug manufacturers often require personal, demographic, diagnostic, therapeutic and financial information as part of the application process. Your signature may also be required on the application. ***For your convenience we are requesting your permission to access and provide the manufacturer's the requested medical/financial information and to sign any application forms as your agent.***

By signing this letter, you authorize Shannon Medical Center to sign any and all forms and applications on your behalf and to access and release any personal demographic, diagnostic, therapeutic, and/or financial information required relating to applications for manufacturer's assistance programs. This authorization may be revoked at any time by contacting the Shannon Medical Center Medication Assistance Program. Furthermore, by signing this letter, you attest that the information you have provided is true and accurate and that any changes in income or insurance status will be reported to Shannon PAP immediately.

______ ______
Patient or Legal Representative Signature (Please provide Power of Attorney) Date/Time

______
Print Name

______ ______
Verified by (technician) Date/Time

Shannon Medical Center

Doc. No. 2104248B.2 01/06

Pharmaceutical Assistance Program

Medications Currently Taking:

Medications	Strength	Directions	Physician	Dr. Phone # if not local	Do Not Order