

Dear Client:

You have been referred to the Medication Assistance Program (MAP) available through Community Action Partnership. This program allows income-eligible individuals to access & apply for free to low-cost medication assistance programs offered by pharmaceutical companies. Community Action Partnership does not pay for any medications, or dispense medications—we act as a connection between the individual and the pharmaceutical companies.

There are no age requirements for the Medication Assistance Program. **If you see a physician outside of the Dickinson Area, please contact us to see if your provider is participating with the Medication Access Program.**

As far as income limits, the drug companies generally go by the following guidelines:

**\$21,660 for a single individual,
\$44,100 for a household of 4**

Each of the 180 companies we work with have their own guidelines—some greater than the above amounts, and some less than the above amounts. **If you have either Insurance or Medicaid that pays for a portion of your prescriptions—please contact Community Action and we will let you know if the companies that make your medications allow any prescription coverage.**

The following items must be returned with you application:

- ✓ **Completed Community Action Intake form (attached)**
 - ✓ **List of current medications (attached)**
 - ✓ **Contract (attached) and \$30.00 quarterly fee**
 - ✓ **Copy of Insurance Card, Medicare Card or Medicare Supplement Card (if Applicable)**
 - ✓ **Verification of ALL household income (earned & unearned)**
 - ✓ **First 2 pages of most current tax return**
- OR**
- ✓ **Social Security benefits page, whichever is applicable.**

If you have any questions, please call 701-227-0131 between the hours of 8:00-12:00 and 1:00-5:00 Monday through Friday. If no one is available to answer your call—leave a voice mail and your call will be returned as soon as possible. Thank you for your interest in the Medication Assistance Program.

Today's Date

COMMUNITY ACTION PARTNERSHIP REGION VIII
 202 EAST WILLARD, DICKINSON, ND 58601
 Phone (701) 227-0131 • Fax (701) 227-4750



CLIENT INTAKE FORM

TYPE OF ASSISTANCE REQUESTED _____

PERSONAL INFORMATION FOR HEAD OF HOUSEHOLD (List additional household members on next sheet)									
Social Security #	First Name	MI	Last Name	Birth Date (mm/dd/yyyy)	Age	Gender	Disabled		
						<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Race	Ethnicity	Education		Fuel Assistance	Food Stamps	Health Coverage	Veteran		
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black	<input type="checkbox"/> Multi <input type="checkbox"/> Native American <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No		

INCOME INFORMATION FOR ALL HOUSEHOLD MEMBERS									
Name	Pay Per Hour	Hours Per Week	Pay Per Month	Total	Income Source/Employer				
	\$		\$	\$					
	\$		\$	\$					
	\$		\$	\$					

HOUSING INFORMATION									
Address	Apt/Lot#	City	County	Zip Code	Telephone #				
Length of Stay at this address:		Years:	Months:	Days:	Just moving:				
Household Type		Marital Status		Housing Status		Housing Type		Rent/House Payment	
<input type="checkbox"/> Female Single Parent <input type="checkbox"/> Male Single Parent <input type="checkbox"/> Two Parent	<input type="checkbox"/> Couple <input type="checkbox"/> Single <input type="checkbox"/> Other	<input type="checkbox"/> Single <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married		<input type="checkbox"/> Owner <input type="checkbox"/> Renter <input type="checkbox"/> Homeless		<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Duplex <input type="checkbox"/> Mobile Home		\$ _____ <input type="checkbox"/> Rental Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	

List all Members of the Household except the Head of Household. (Primary Person listed on the front of this form)

Name (Please Print)	Social Security #	Birth Date	Age	Relation	Gender	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Race	Hispanic/ Latino <input type="checkbox"/> Yes <input type="checkbox"/> No	Education	Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No	Health Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran <input type="checkbox"/> Yes <input type="checkbox"/> No
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Medication Assistance Agreement
Patient/Provider Contract

***Both parties involved reserve the right to withdraw due to failure to comply with the following contract:**

Patient Responsibilities:

- A \$30.00 quarterly fee is required for processing, mailings, faxes and phone calls. This fee is NON-REFUNDABLE even if you are turned down by the pharmaceutical company for any reason.
- Must supply Medication Assistance Specialist with the following
 - ❖ Completed Community Action Intake form (attached to initial application)
 - ❖ List of current medications and doctor(s) names
 - ❖ Copy of any insurances cards you may have
 - ❖ Verification of all HOUSEHOLD income such as but not limited to; first 2 pages of most current tax return, social security benefits page or pay stubs

Any changes in any of the above MUST be reported immediately!

- Appointments are required if you want to meet to the Medication Assistance Specialist. Call during business hours of 8-5 (closed from 12-1 for lunch) at 701-227-0131. No phone calls will be taken at home.
- Refills are NOT automatic, they are your responsibility. You must notify the Medication Assistance Specialist of refills needed when you have a month and a half of medication left.

Patients may be dis-enrolled for not completing any of the above steps. If a patient chooses to dis-enroll or is dis-enrolled from the program by the Medication Assistance Specialist for not complying with the above rules, there will be a three (3) month waiting period to re-enroll.

Medication Assistance Specialist Responsibilities:

- Timely processing of applications related to medication assistance workload.
- Phone calls will be returned in a timely manner.
- Notification of ineligibility and/or rejection from the pharmaceutical companies.
- Confirming patients reported medications with their doctor and obtaining doctor's signatures on applications and prescriptions.

By signing this contract, I hereby state I will fulfill patient responsibilities as listed above.

Patient Signature

Date

***Note: All medications will be delivered to the patient's doctor's office or the patient's home depending on the policies of the pharmaceutical company.**

AUTHORIZATION FOR RELEASE OF INFORMATION

Community Action Partnership
 202 East Villard, Dickinson, ND 58601
 Phone: (701) 227-0131 Fax: (701) 227-4750

From: Community Action Partnership 202 E Villard Dickinson, ND 58601		To:	
Client's Name:		Address:	
Date of Birth:	Phone Number:	Social Security Number:	

- Client requests that you release their records to us for: **(check each box requested)**
- Diagnosis and treatment
 Legal
 Personal
 Insurance billing
 Military
 Screening
 Other _____
- Client request that their records be released to your clinic.
- Client authorizes the release of sensitive records. **(Initial on each line requested)**
- Mental Health
 HIV Records
 Chemical Dependency
- Client requests to hand carry records.
- Client authorizes communication between agencies.
- Client authorizes general release for last 5 years.
- Client authorizes release for time period of _____ to _____.

Client requests the following specific information be released: _____

To Coordinate Services

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- o This authorization will remain effective until the following date, event or condition: _____
 If there is no date, event or condition, it will remain effective for 1 year and will automatically expire without my express revocation. I understand that I can revoke this authorization at any time upon written request. Any information released prior to my written revocation of this authorization will not be a breach of confidentiality.
- o I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed under this authorization.
- o I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. Medical treatment to the patient is not conditioned on the signing or failure to sign this form.
- o I understand that if the individual or organization that receives this information is not a healthcare provider or health plan covered by the federal privacy regulations, the information released to the above may be redisclosed and is no longer protected by these federal regulations.

X _____ Date
 Signature of Client or Legal Representative

Relationship to client:
 Parent of Minor
 Legal Guardian
 Next of Kin
 Power of Attorney for Health Care

_____ Date
 Witness



Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE HAVE A LEGAL DUTY TO PROTECT YOUR INFORMATION

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. We understand the importance of keeping your information private and make it one of our top priorities. We are required by law to protect the privacy of your information. Your information is referred to as "protected health information" (PHI). PHI is your health information and other information that identifies you such as your name, address, telephone number and benefit plan number.

This notice explains how, when, and why we collect use and disclose your information and about your rights concerning your information. We must follow the privacy practices described in this notice beginning April 14, 2003. This notice will remain in effect until we modify it.

We may change our privacy practices and this notice at any time. Any changes will apply to the PHI we already have. When we make a significant change in our privacy practices, we will change this notice and make it available upon request and post it in our agency.

You may request additional copies of this notice from the contact number listed on the last page of this notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose PHI for many reasons. Under some circumstances, we are allowed by law to use and disclose your PHI without your authorization. Under other circumstances, we need your authorization to use and disclose your PHI. In all cases, we use and disclose only the minimum amount of information necessary to satisfy the purpose of the use or disclosure.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Business Associate: Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, certification, licensing or credentialing activities.

Parental Access: Generally, parents, guardians or other people acting in a similar legal capacity may receive their minor child's PHI. However, some state laws give minors special protections and require that we cannot disclose the minor's PHI to the parents, guardians or others without the written authorization of the minor.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your PHI to the appropriate authorities to report child abuse or neglect or when there is a concern that you have been a victim of abuse, neglect or domestic violence.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Community Action Partnership
202 East Villard
Dickinson, ND 58601
Phone: (701) 227-0131
Fax: (701) 227-4750

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- o Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- o Obtain payment from third-party payers
- o Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the client's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason