VCU Health Community Memorial Hospital
Location: 2nd Floor of the CARE Building
Pharmacy Connection Program
1755 N. Mecklenburg Ave
P.O. Box 90
South Hill, VA 23970
Phone: 434-447-0856
Fax: 434-447-0858
Email: samantha.lewis@vcuhealth.org

Thank you for your interest in the VCU Health CMH Pharmacy Connection Program, a medication assistance program for individuals that are uninsured or underinsured. The following information is needed from you to complete the application process:

1. **Proof of income**: Attach copies of proof of income for you and *any member who contributes to the household income.* Acceptable documents: Federal Income Tax (form 1099 or 1040EZ) with appropriate schedules (C and/or F) OR Social Security benefit statement, or award letter. Current pay stub for all employers (within the last 2 months)

2. **Proof of insurance**: copies of all insurance cards **(front and back)** including prescription assistance cards

Once I have all the above information, I can then begin the application process with the pharmaceutical companies to see if you meet their eligibility requirements for free or reduced cost medication(s).

Thank you.

Samantha Lewis, BSW

Medication Assistance Coordinator/Pharmacy Connection Patient Advocate

VCU Health
Community Memorial Hospital

Pharmacy Connection
*A **FREE** COMMUNITY SERVICE PROVIDED AS A COURTESY TO PATIENTS IN THE VCU CMH SERVICE AREA*

Patient Instructions
Medication Assistance Program

Yours to Keep

1. Medication manufactures require certain paperwork regarding patient's income. The medication assistance coordinator will explain the paperwork needed, but medications cannot be requested until VCU CMH Pharmacy Connection office receives **all** the paperwork. Once paperwork is received and applications have been mailed, it could take 4-6 weeks for the medicine to be sent by the drug companies, sometimes longer.

2. There is no guarantee that the drug companies will send your medicine. They will determine if you are eligible. Sometimes they discontinue medicines from their program. All medicines may not be available in medication assistance programs, and you may have to continue to purchase some of your medicines. The coordinator will go over the medication list and determine which medicines are available in the program.

3. We will do our best to help you, but please DO NOT count on this program as your **only** source of medication. Be prepared to pay for your medicines or get samples if necessary.

4. Some medications can ship to your home, and some must be delivered to your physician's office. If delivered to the office, your physician's office will call you to let you know when they have arrived. **Note: Please call us at (434) 447-0856 when you receive your medication, whether by mail or through physician's office.**

5. **It is very important that you call us when you have 30 days (4 weeks) left of your medicine.** We need to order refills before you run out of medicine. You will usually receive a 90-day supply. Please use your calendar to remind yourself when to call us. When you need a refill please call us at (434) 447-0856 and leave a voicemail. ***Be prepared to buy your medication if it does not come in before you need it. ***

6. If your medications change, for any reason, please contact us immediately. Your doctor may increase, decrease, or stop medication or add new medication. YOU MUST tell us if any changes occur.

7. The drug companies may send you paperwork. Please call if you receive paperwork. There may be Rx numbers or refill applications that will make it easier for us to reorder.

It is the patients' responsibility to notify the medical center staff 4 weeks before the last dose of medication is taken so the reorder process can take place in a timely manner.

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Personal History (Please Print)

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Full Name: _____ Gender: ☐ Male ☐ Female

Address (Mailing & Physical): _____

_____ _____ _____
City State Zip

Home Phone: _____ Cell Phone: _____ County: _____
Social Security #: _____ Date of Birth: _____

Email Address:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Ethnicity: ☐ African –American ☐ Asian ☐ Caucasian ☐Hispanic ☐ Native American ☐ Other
Primary Care Physician: _____
Referring Doctor: _____
Allergies to medications: ☐ No ☐ Yes, if so which one(s)? _____

Current Medications *(attach a separate list, if necessary, with strengths and dosage instructions):*

_____

Health Conditions: _____

PROGRAMS REQUIRE INCOME FROM ALL MEMBERS OF THE HOUSEHOLD MUST BE STATED.

People in household: ____ Total Monthly Income: $_____

Source of Income:
Employment: $ _____ EBT/Other: $ _____
Social Security: $ _____ Alimony/Child Support: $_____
Disability: $ _____ Pension/Retirement: $_____

Medical Coverage Information (Please check if applicable)

Do you have Medical Coverage? ☐Yes ☐ No

Medicare	☐ Yes	☐ No	Medicare Part D	☐ Yes	☐ No
Supplement Policy	☐ Yes	☐ No	Are you a Veteran?	☐ Yes	☐ No
Medicaid	☐ Yes	☐ No	VA Benefits?	☐ Yes	☐ No

Do you have Prescription Coverage ☐ Yes ☐ No
If yes, name the provider _____

Please read and initial each statement.

____ I certify that the information supplied on this form is accurate to the best of my knowledge. I agree to contact VCU Health CMH's Pharmacy Connection if any of the information requested on this form changes, including but not limited to address, phone number(s) and household income. I understand that Pharmacy Connection will attempt to assist me in obtaining free medication(s) typically in a 90-day supply (3-month supply) and that it is my responsibility to contact Pharmacy Connection immediately of any medication(s) changes.

____ I hereby authorize the VCU Health CMH's Pharmacy Connection Medication Assistance Caseworker/Advocate to sign my name on all necessary pharmaceutical form(s) that may be required for ordering my needed medications. This signature authorization is valid if I am receiving services through VCU Health CMH's Pharmacy Connection.

____ Please call us for a refill 30 days before your supply of each medication runs out.

____ Please advise our office any mail/documents you receive from drug manufacturers, and do not complete this paperwork until you check with us. This will ensure that the manufacturer does not remove you from the program due to duplicate applications/requests. This will prevent medication manufacturers from receiving more than one application on your behalf.

____ I have been given a patient's copy of Patient Instructions.

____ I have been given a copy of the VCU Health Community Memorial Hospital's Notice of Privacy Practices that describes how my health information is used and disclosed.

_____ _____

Patient Name (please print) Signature or Legal Representative/Date

Witnessed by:

_____ _____

Name (print) Signature/Date

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Authorization to Share Healthcare Information

I _____, give permission to the Medication Assistance Caseworker/Patient Advocate for VCU Health CMH's Pharmacy Connection to access all medical information necessary to enroll me in the prescription assistance program. This authorization does not expire unless I date this information.

I give permission to Medication Assistance Caseworker/Patient Advocate VCU Health CMH's Pharmacy Connection to speak with, **other than myself**, the person(s) listed below regarding my enrollment in VCU Health CMH's Pharmacy Connection, to leave a verbal message for me, and/or respond to any messages left for the Medication Assistance Caseworker/Patient Advocate.

_____ _____

Name (please print) Telephone Number

_____ _____

Name (please print) Telephone Number

_____

Patient Signature or Legal Representative