Central Oklahoma Community Action Agency

Rx for Oklahoma – Prescription Assistance Service
2270 Industrial Blvd. Norman, Oklahoma 73069
Phone: (405) 701-1497 Fax: (405) 701-1536
www.cocaa.org

PLEASE PRINT **PLEASE COPY ALL INSURANCE CARDS AND ATTACH FINANCIAL VERIFICATION**

Date: ________________________ **Have we assisted you before?** **YES** **NO**

Name: __________________________ ________ ____
(First) (MI) (Last)

Street Address: ____ **City:** ______________________________

State: ________ **Zip:** ___________ **County:** ________________ **Phone:** (________)________________

SSN: ________-______-________ **Date of Birth:** ________________ **Sex:** ☐ **M** ☐ **F**

Education Level Completed: ________________

Marital Status: Married _____ Divorced _____ Single _____ Widowed _____

Race: Caucasion _____ Black or African American _____ American Indian or Alaska Native _____

Asian _____ Native Hawaiian or other Pacific Islander _____ Other _____

Multi-Race _____ (Any two or more of the above)

Ethnicity: Hispanic YES NO **(circle one)**

Household: ☐**Head** ☐**Spouse** ☐**Dependent Child** **Number in household: ___Adults ___Children**

Family Type: Single Parent Female __________ Single Parent Male __________

Two Parent Household __________ Two Adults no Children _______ Other________

Housing: (circle one) Own Rent Shelter Stay with Family/Friends other: __________ (specify)

Employment Status: ☐ **Full** ☐ **Part** ☐ **Not in Labor Force** ☐ **Retired** ☐ **Unemployed**

Are you a U.S. Citizen? YES NO **Are you disabled? YES NO** **Are you a Veteran? YES NO**

INCOME INFORMATION

Please enter your MONTHLY household income from all sources - ***Please Attach Financial Verification***

Wages $______________ Unemployment $______________ Workers Compensation $______________

Social Security Retirement $______________ Social Security Disability $______________ TANF _________

Other Disability $______________ Retirement $______________ Alimony/Child Support $______________

Other $______________ ________________________ **Total *Monthly* Household Income** $______________
(Specify Source)

Did you file a tax return last year? YES NO Will you file a tax return this year? YES NO

INSURANCE INFORMATION
Please copy and attach ALL insurance cards, front and back, including Medicare and Medicaid

Please check all that apply:

Do you have prescription insurance? YES NO

Are you enrolled in Medicare Part D? YES NO

☐ Medicare (Medicare #___________________) ☐ Medicare Discount Card

☐ Medicaid ☐ Private Health Insurance (Company __________________)

☐ None

Reference

How did you hear about this program? (Please circle one.)

Action Agency Community Clinic	Employer Flyers
County Health Department	Friends/Family
DHS	Health for Friends
Doctors Office	Hospital
Legislative Office	Social Services
Newspaper	TV/Radio
PPA-RX	Website/Internet
Presentation	Word of Mouth
Senior Advisor	Other __________________

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RELEASE OF CONFIDENTIAL INFORMATION

The Prescription Assistance Service, ***RX for Oklahoma***, is designed to address the medication needs of individuals in our community. This program participates with pharmaceutical manufacturers to offer assistance and provide medications to low-income or uninsured people. These medication manufacturers often require personal demographic, therapeutic, and financial information as part of the application process. For you convenience, we are requesting your permission to access and provide the manufacturers with the requested medical and financial information, as needed.

By signing this statement you authorize the Prescription Assistance Service to complete any and all forms and applications for drug manufacturer assistance programs. This authorization may be revoked at any time by contacting RX for Oklahoma prescription assistance program. The individual signing this document reserves the right to appeal any decision made regarding assistance provided by RX for Oklahoma participating partners. The right to appeal does not guarantee the right to modify individual pharmaceutical company policies and procedures.

____________________________ ______________ ______________________________
(Client signature) (Date) (Client signature Printed)

____________________________ ______________ ______________________________
(Witness For the Agency) (Date) (Witness Signature Printed)

****Administrative Use Only****

Address and Telephone Number of the CAA office/center or Partnering Clinic where this statement was signed

____
(Facility Name) (Address) (Phone)

Primary Physician Information:

Physician Name: ____ **Phone:** (_______)__________________

Street Address: ____

City: __________________________ **State:** ______ **Zip:** ____________ **Years with Physician:** _______

Please list all prescriptions. If medication was prescribed by a different physician than the one listed above, circle "NO" and complete the new physician information.

PRESCRIPTION 1: **Primary Physician YES NO**

Prescription Name: ____ **Dosage:** __________________

Physician Name: ____ **Phone:** (_______)__________________

Street Address: ____

City: __________________________ **State:** ______ **Zip:** ____________

RX Office Use Only:
PAP: ______________________________

PRESCRIPTION 2: **Primary Physician YES NO**

Prescription Name: ____ **Dosage:** __________________

Physician Name: ____ **Phone:** (_______)__________________

Street Address: ____

City: __________________________ **State:** ______ **Zip:** ____________

RX Office Use Only:
PAP: ______________________________

PRESCRIPTION 3: **Primary Physician YES NO**

Prescription Name: ____ **Dosage:** __________________

Physician Name: ____ **Phone:** (_______)__________________

Street Address: ____

City: __________________________ **State:** ______ **Zip:** ____________

RX Office Use Only:
PAP: ______________________________

PRESCRIPTION 4: **Primary Physician YES NO**

Prescription Name: ____ **Dosage:** __________________

Physician Name: ____ **Phone:** (_______)__________________

Street Address: ____

City: __________________________ **State:** ______ **Zip:** ____________

RX Office Use Only:
PAP: ______________________________

PRESCRIPTION 5: Primary Physician YES NO

Prescription Name: ______________________________ Dosage: ______________

Physician Name: ______________________________ Phone: (________)______________

Street Address: ____

City: ____________________ State: ______ Zip: __________

RX Office Use Only:
PAP: ______________________

PRESCRIPTION 6: Primary Physician YES NO

Prescription Name: ______________________________ Dosage: ______________

Physician Name: ______________________________ Phone: (________)______________

Street Address: ____

City: ____________________ State: ______ Zip: __________

RX Office Use Only:
PAP: ______________________

PRESCRIPTION 7: Primary Physician YES NO

Prescription Name: ______________________________ Dosage: ______________

Physician Name: ______________________________ Phone: (________)______________

Street Address: ____

City: ____________________ State: ______ Zip: __________

RX Office Use Only:
PAP: ______________________

PRESCRIPTION 8: Primary Physician YES NO

Prescription Name: ______________________________ Dosage: ______________

Physician Name: ______________________________ Phone: (________)______________

Street Address: ____

City: ____________________ State: ______ Zip: __________

RX Office Use Only:
PAP: ______________________

PRESCRIPTION 9: Primary Physician YES NO

Prescription Name: ______________________________ Dosage: ______________

Physician Name: ______________________________ Phone: (________)______________

Street Address: ____

City: ____________________ State: ______ Zip: __________

RX Office Use Only:
PAP: ______________________

If you have more medications than space available, please ask for an additional prescription form or attach your own sheet with the required information.