



Central Oklahoma Community Action Agency
Rx for Oklahoma – Prescription Assistance Service
429 N. Union Shawnee, OK 74801
Phone: (405) 275-6060 Fax: (405) 214-4326
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: Caucasian _____ 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 \$ _____ (Specify Source) **Total Monthly Household Income \$ _____**

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

County Health Department

DHS

Doctors Office

Legislative Office

Newspaper

PPA-RX

Presentation

Senior Advisor

Employer
Flyers

Friends/Family

Health for Friends

Hospital

Social Services

TV/Radio

Website/Internet

Word of Mouth

Other _____



CENTRAL OKLAHOMA COMMUNITY ACTION AGENCY

429 North Union Street
Shawnee, Oklahoma 74081
Phone: (405) 275-6060 Fax (405) 214-4326

www.cocaa.org



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.