

## MEDBANK



c/o Whitfield Co. Health Dept.  
800 Professional Blvd.  
Dalton, GA 30720  
Phone: (706) 281-2363

Dear Patient:

MEDBANK is a program of the Whitfield County Health Department. MEDBANK will try and help get your medications directly from the pharmaceutical companies that manufacture the medications. It is the pharmaceutical companies' patient assistance programs (PAP) and the medication they send is at no charge.

MEDBANK, however, charges a service fee to each patient of \$10.00 per month to process, order and label the medicine for you. This is NOT \$10.00 per medication.....it is just \$10 per month no matter how many medications we order for you, or how many medications you do or don't pick-up every month. A total of \$120 per patient a **year** is the total cost. Your first monthly payment is due when you pick-up your first medication.

**Please carefully read the attached information that you have received. You will need to make sure you have everything together before we can begin the application process.** This means you will need to:

- 1) Have the *Physician Referral Form* completed by your doctor (your doctor and/or nurse will fill out this form at their office);
- 2) Understand that there are income guidelines, which are set by each individual drug company;
- 3) Have all of the financial information together that applies to **you and your household** (see *Financial Information* form).
- 4) If you have ever received any type of help during this year in getting your medications, please indicate that on the "Patient Information" sheet.

Please understand that MEDBANK has no control over the availability of medications in the prescription assistance programs nor does MEDBANK have control over the qualification(s) that the drug companies may require to receive their medications. Once your application is sent to the drug company(s), it can take four (4) to eight (8) weeks before you become qualified AND to receive your medication(s). It is therefore **your** responsibility to make sure you have an adequate supply of your medicine(s) until that time.

We look forward to being of service to you!

Please read the next page carefully.

At this point, you need to make sure you have spoken with your doctor(s) about MEDBANK and ask to have the physician referral form(s) sent to us.

MEDBANK can not help you unless you provide us with all the information that is asked from you.

ALSO:

You have to provide MEDBANK with some type of proof of income. If you say “Yes” to anything on the following worksheet, we need to have a copy of that income source.

If you have no income, then who is supporting you? Who pays for your rent, food, utilities, etc?

If you have “zero” income at the time of this application, then MEDBANK will need a NOTARIZED statement from that person or persons who are paying for your way. It needs to say how much they give you each month.

OR

If you have “zero” income at the time of this application, and you are living with your parents, a friend, a relative, or a significant other, then MEDBANK needs proof of their monthly and yearly income.

If you have “zero” income at the time of this application, you also have to provide MEDBANK with a Medicaid denial letter (you get this letter from the Dept. of Family and Children Services) that says you are not eligible to receive medical help.

If you have any questions about this process, please call us.

Our goal is to help you on your path to a healthier lifestyle which includes getting your medications!

Please read the next page carefully.

**Please return this completed form.**

Patient Name: \_\_\_\_\_

**FINANCIAL INFORMATION**

So we can process your application as quickly as possible, we will need any and all of the following information that applies to you and your household.

If you say “Yes” to ANY of the following, then MEDBANK needs a **copy** of each document that applies to you and your household.

\_\_\_\_\_ If you filed a Federal tax return for 2009, we will need a **copy** of the return. **OR**

\_\_\_\_\_ If you filed a Federal return for 2010, we will need a **copy** of the return.

\_\_\_\_\_ Are you or anyone in your household currently employed? If YES, we will need **copies** of the most recent paycheck stubs for the past **month** from EVERYONE who is working.

\_\_\_\_\_ Are you claiming ‘zero’ income? If so, you will need 1) a NOTARIZED letter of support and 2) a Medicaid denial letter from the Department of Family and Children Services that says you are not eligible for medical help.

\_\_\_\_\_ Do you or anyone in your household receive benefits from Social Security? If YES, we will need from everyone in your household receiving Social Security benefits these two (2) items:

1) a **copy** of your **2011** benefit statement which indicates what your current dollar amount is for each month (a copy of your Social Security check is acceptable).

**AND**

2) a **copy** of your Social Security form SSA-1099 for **2010**.

You can get these two (2) forms for you and everyone in your household from the local Social Security Office or call their toll-free number at 1-800-772-1213 and request copies.

\_\_\_\_\_ Do you or anyone in your household receive income from any other source, such as, but not limited to, a pension plan, interest income, unemployment benefits, insurance premiums, etc.? If YES, we will need a **copy** of the source’s 2009 year-end statement and a copy of the source’s monthly check in 2010.

\_\_\_\_\_ Do you (as the person applying for help) have medical/health insurance provided by a private health insurance policy? If YES, we will need **copy(s)** of the insurance card(s) (front and back copy) which shows the name and address of the insurance company, the telephone number and policy number.

**Failure to return any of the above information that applies to you and your household will delay the application process.**

**ALL INFORMATION YOU FURNISH TO US IS TREATED WITH THE UTMOST RESPECT AND CONFIDENTIALITY.**

**Please return this completed form.**

**MEDBANK**

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Phone: (706) 281-2363  
Fax: (706) 876-1558

**PATIENT INFORMATION**

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_  
Last First MI

Street Address: \_\_\_\_\_ City Zip

Mailing Address: \_\_\_\_\_ City Zip

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status (please circle): Single Divorced Separated Married Widowed

**Please make sure you list a phone number where we can leave a message:** Phone # \_\_\_\_\_

Is this phone # for: Home? Work? Cell? Other? \_\_\_\_\_

Do you have a Medicare card? Yes\_\_\_\_ No\_\_\_\_ If Yes, Please **STOP**- you may need to apply for Medicare D or provide a LIS denial letter on the Medicare Part D from Social Security.

Do you have GA Medicaid card? Yes\_\_\_\_ No\_\_\_\_  
If Yes, does your Medicaid cover the cost of ANY medications? Yes\_\_\_\_ No\_\_\_\_

Have you **ever** applied for Medicaid and were **denied**? Yes\_\_\_\_ No\_\_\_\_ If YES, PLEASE ENCLOSE A COPY OF YOUR MEDICAID **DENIAL** LETTER WITH THIS FORM.

Are you a Veteran? Yes\_\_\_\_ No\_\_\_\_

Are you **legally** disabled? Yes\_\_\_\_ No\_\_\_\_ If Yes, how long have you been disabled? \_\_\_\_\_

Do you have private medical insurance? Yes\_\_\_\_ No\_\_\_\_ Does it cover medications? Yes\_\_\_\_ No\_\_\_\_

How many people live in your household? Adults\_\_\_\_ Children\_\_\_\_

Have you ever received help in getting your medications free or at a discount? (not samples from your Doctor)  
Yes\_\_\_\_ No\_\_\_\_

If YES, where were you getting help and when was the last time you got these medications? \_\_\_\_\_

Who is your Doctor (s)?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**MEDBANK**  
**Authorization to Share Health Information**  
**For Prescription Assistance Program**

I, \_\_\_\_\_, allow my doctor(s), any other health care providers, advocate, and my health plan or insurers to give medical information relating to my use or need for MEDBANK in getting help with my prescriptions.

This information can include spoken or written facts about my health and payment benefits I may have. It can include copies of records from my health care providers or health plans about my health or health care.

MEDBANK will use and give out this information to see if I qualify for the Prescription Assistance Program and to run the Prescription Assistance Program. People who work for and with MEDBANK may also see my information, but they may use it only to help me get assistance with the cost of my prescriptions. I understand that they will make every effort to keep my information private. If it is accidentally given out, I understand that the federal Privacy Rule (“HIPPA”) does not protect the privacy of information if disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, service or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

- (    ) ninety (90) days unless I specify an earlier expiration date here: \_\_\_\_\_  
( X ) one (1) year.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

This Authorization will last until I am no longer participating in MEDBANK’s Prescription Assistance Program. If I change my mind before that, I can tell my health care providers and my insurers in writing that I do not want them to share any more information with MEDBANK, but it will not change any actions they took before I told them. I know I have a right to see or copy the information my health care providers or insurers have given to MEDBANK.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from MEDBANK.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

If the patient cannot sign, patient’s personal representative must sign below:

Patient Name: \_\_\_\_\_

By: \_\_\_\_\_

(Signature of person signing)

Describe the relationship to patient and authority to make medical decisions for patient:

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**PATIENT SIGNATURE AUTHORIZATION**

I authorize representatives of MEDBANK to sign forms on my behalf for the sole purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as MEDBANK is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

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**UNDERSTANDMENT OF PAYMENT**

I understand that there is a monthly charge to each patient of \$10.00 **every** month.

I understand that this is NOT \$10.00 per medication.

I also understand that the charge is just \$10 per month no matter how many medications I may pick up during a month.

I also understand that there is still a \$10 charge per month even if I do not pick up a medication in any given month.

FULL PRINTED NAME OF PATIENT: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Please return this completed form**