Louisiana SenioRx
Linking Seniors to Pharmaceutical Aid

Please complete and return to:
the Louisiana SenioRx Program that serves your area

CLIENT APPLICATION

Social Security Number: _____ Medicare Number: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ Street Address: _____

City/Zip: _____ Parish: _____ Home Phone: _____

Race/Ethnicity: White _____ African American _____ Hispanic _____ Other _____

Gender: ____Male ____Female Birth date: ____/____/_____ Rent ___ Own ___ Other ____

Emergency Contact
Name: _____ Address: _____
Phone: _____ Relationship: _____

Did you file income taxes last year? ____Yes ____No Are you a legal U.S. resident? ____ Yes ____No

Employment Status: ____Retired ___Disabled
____Full time ___Part time

Are you a veteran or veteran's spouse/widow?
____Yes ____No

Marital Status: ___Married ___Single ___Widowed Spouse's Social Security Number: _____

Spouse's Name: _____ Number living in household (including client): _____

ATTACH COPIES OF YOUR PROOF OF INCOME (SOCIAL SECURITY LETTER or W2)

TOTAL MONTHLY INCOME $ _____ TOTAL ANNUAL INCOME $_____

Salary/Wages $_____ Unemployment $_____ Social Security Disability $_____

Veteran's Benefits $ _____ Child Support $ _____ Social Security $ _____

Workman's Comp $ _____ Pension $_____ SSI $ _____

Railroad Retirement $ _____ Interest Income $ _____ Other (i.e. public assistance) $_____

ATTACH COPY OF INSURANCE CARD WITH APPLICATION (FRONT and BACK)

TOTAL MEDICAL EXPENSES $_____ (over-the-counter medicines, copays, supplies, doctor visits, etc.)

PRESCRIPTION DRUG COSTS $ _____ (monthly average)

Are you currently enrolled in any prescription assistance or discount programs? ____Yes ____ No

Do you have insurance covering prescription drugs? ____Yes ____No

Have you voluntarily canceled state, federal, or private prescription coverage within six months? ___Yes ___No

Are you enrolled in ____Medicare ____ VA Benefits ____ SLMB ____QMB # _____

Do you have any health insurance coverage? _____
Company Policy #

Do you have Medicare Supplemental Policy? _____
Company Policy #

The Louisiana SenioRx Program is administered by the Governor's Office of Elderly Affairs.
The information being collected will be kept STRICTLY CONFIDENTIAL.

PLEASE LIST ALL MEDICATIONS YOU NEED HELP OBTAINING.

Medication	Primary Diagnosis	Directions/Strength	Prescribing Doctor and Phone	Manufacturer and Cost
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
20.				

PLEASE LIST YOUR DRUG ALLERGIES: _____

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PLEASE LIST CONTACT INFORMATION FOR ALL THE PHYSICIANS WHO PRESCRIBE YOUR MEDICATIONS?

Name	Address	Phone Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I hereby state that the information I have given is correct to the best of my knowledge and the Louisiana SenioRx Program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand that the Louisiana SenioRx Program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services.

Signature: _____ Date: _____

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PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give permission to authorized representatives of the Louisiana **SenioRx** to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize **SenioRx** to discuss my medical needs and me with my physician when necessary. Additionally, I give **SenioRx** permission to verify my income through the Social Security Administration, my employer, Veterans Administration or any other company, business or organization from which I receive income. This authorization is good as long as **SenioRx** is assisting me or until I revoke such.

I want a copy of this form to be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

DOB: _____ SSN: _____

ADDRESS: _____

FULL PRINTED NAME OF PATIENT: _____

SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of Louisiana **SenioRx** to sign forms on my behalf for the 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 **SenioRx** is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: _____

SIGNATURE: _____ DATE: _____

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SenioRx Program Reminders

Thank you for allowing us to help you with your medication needs. We hope this service will be of great benefit to you.

Just a couple of reminders:

1. All personal information will be kept strictly confidential.

2. You will be mailed your completed pharmaceutical application to sign. You will be required to obtain your physician's information and signature if necessary.

3. Please remember that each pharmaceutical company has individual requirements for eligibility. SenioRx cannot guarantee that you will receive all medications requested and we may ask you to provide more specific information.

4. Most of the pharmaceutical companies mail the free prescription medications directly to the physician for distribution. You will be notified when your medications arrive at your physician's office. Discount drug cards will be mailed directly to you.

5. Please contact your local SenioRx coordinator at the number listed below if you have not received your medications within 2 months after signing your final pharmaceutical applications.

6. **Please let SenioRx know when you receive your first medication**. This begins the process for obtaining your refills.

7. You will also need to call SenioRx **at least 30 days before your medication runs out to complete the refill process.** Depending on manufacturer, some clients will be able to request their own refills. A reminder sheet will be provided for those clients that can do so.

Please let us know if we can be of further assistance.

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CLIENT CHECKLIST

This application packet should be mailed back to your SenioRx Program (listed at the top) with ALL the requested information. **Please verify that you have attached each item by filling out the check list, then sign and return with your application.**

____ Completed application

____ Completed and signed "Patient Consent and Release Form"

____ Proof of income for each member of household (current tax form, Social Security Benefit letter or current bank statement)

____ List of medications and all physician information required on application

____ Proof of insurance (copy of cards)

I understand that failure to include all requested information will delay completion of my application.

Signature: _____ Date: _____

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