Beacon Charitable Pharmacy
Phone: (330) 445-1087 Fax: (330) 445-1075

PHARMACY INTAKE APPLICATION

Date: _____ ***Client referred by:*** _____

Intake Person/Site: _____ ***Photo ID Viewed:*** ☐ Yes ☐ No

CLIENT INFORMATION:

Last Name: _____ ***Initial:*** ____ ***First Name:*** _____

Phone: _____ ☐ ☐ ☐ ***Home/Cell/Work*** ***Other Contact Number:*** _____

Street Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

D.O.B. _____ ***S.S. Number:*** _____ ***U.S. Citizen:*** ☐ Yes ☐ No

Gender ☐ Male ☐ Female ***Disabled*** ☐ Yes ☐ No

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Ethnicity ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Hispanic/Latin ☐ Other

☐ Native American/Native Alaskan ☐ Multi-Race (any 2 or more) ☐ Native Hawaiian

Education: ☐ 0-8 ☐ 9-12 (Non-Grad) ☐ HS Grad/GED ☐ 12+ ☐ 2-4 yr. Grad College

Health Insurance: ☐ Medicaid ☐ Medicare ☐ None ***Veteran:*** ☐ Yes ☐ No

Sources of Income	Yes	No	Monthly Amount Self	Other Household Member(Relationship) With Income	Amount For Other Household Member
Employment / ☐ Workman's Comp ☐	☐	☐			
Unemployment	☐	☐			
SSI/SSD	☐	☐			
Social Security	☐	☐			
Pension / ☐ Student Loans ☐	☐	☐			
Alimony or Child Support	☐	☐			
Food Allowance	☐	☐			
Total			**$ 0.00**		**$ 0.00**

Total MONTHLY Income (all sources): **$ 0.00** ***Total ANNUAL Income (all sources):*** $ 0.00

Number of People in Household: _____

PRESCRIPTION INFORMATION:

Diagnosis/Condition: _____

Allergies? ☐***Yes*** ☐***No If yes, please list:*** _____

Physician's Name: _____

Address: _____ ***Suite:*** _____ ***City:*** _____ ***State:*** _____ ***Zip*** _____

Phone number: _____ ***Fax number*** _____ ***Dea#*** _____

State License# _____ ***Medical Specialty***_____

* (MAP)	Medication Name	Dosage	Quantity	New Rx	Exist. Rx	If Existing Rx, Name of Pharm	Pharm Phone Number

Diagnosis/Condition: _____

Physician's Name: _____

Address: _____ ***Suite:*** _____ ***City:*** _____ ***State:*** _____ ***Zip*** _____

Phone number: _____ ***Fax number*** _____ ***Dea#*** _____

State License# _____ ***Medical Specialty***_____

* (MAP)	Medication Name	Dosage	Quantity	New Rx	Exist. Rx	If Existing Rx, Name of Pharm	Pharm Phone Number

Notes:

Beacon Charitable Pharmacy
Client Reporting Form

Client Name: _____

Client Address: _____

City: _____ Zip Code: _____

Township: _____

Insurance : Yes☐ No☐ Disabled? ☐Yes ☐No

Race of Client: (Please check only one race)

Single Race Persons
- ☐White
- ☐Black or African American
- ☐American Indian or Alaska Native
- ☐Asian
- ☐Native Hawaiian or Other Pacific Islander

Multi-Race Persons ☐
- ☐American Indian or Alaska Native and White
- ☐Asian and White
- ☐Black or African American and White
- ☐American Indian or Alaska Native and Black
- ☐Other Multi-Racial _____

Single Parent Household ☐Yes ☐No

Client Gender ☐ Female ☐ Male

Ethnicity of Client: Is Client Hispanic or Latino? ☐Yes ☐No

Beacon Charitable Pharmacy

I hereby attest that I am not covered by any form of health insurance, including Medicare D,Medicaid, or private insurance.

Source:	***MONTHLY Amount:***	***ANNUAL Amount total:***
_____	$ 0.00	$ 0.00
_____	$ 0.00	

Household Size	Annual Income Range	Household Size	Annual Income Range
1 Person Household ☐	0 -12,490 ☐ 24,981 - 31,225	5 Person Household ☐	0 – 30,170 ☐ 60,341- 75,425
☐	12,491 – 17,236	☐	30,171– 41,635
☐	17,237 – 18,735	☐	41,636 – 45,255
☐	18,736 – 24,980	☐	45,256– 60,340
2 Person Household ☐	0 – 16,910 ☐ 32,821 - 42,275	6 Person Household ☐	0 – 34,590 ☐ 69,181 - 86,475
☐	16,911– 23,336	☐	34,591 – 47,734
☐	23,337 – 25,365	☐	47,735– 51,885
☐	25,366 – 33,820	☐	51,886 - 69,180
3 Person Household ☐	0 – 21,330 ☐ 42,661- 53,325	7 Person Household ☐	0 – 39,010 ☐ 78,021 - 97,525
☐	21,331 – 29,435	☐	39,011 – 53,834
☐	29,436– 31,995	☐	53,835 - 58,515
☐	31,996 – 42,660	☐	58,516 - 78,020
4 Person Household ☐	0 – 25,750 ☐ 51,501 - 64,375	8 Person Household ☐	0 – 43,430 ☐ 86,861- 108,575
☐	25,751 – 35,535	☐	43,431 – 59,993
☐	35,536 – 38,625	☐	59,994 - 65,145
☐	38,626– 51,500	☐	65,146 - 86,860

I certify that all information I have provided is accurate and completed to the best of my knowledge. I will report any change in financial status or insurance status to Beacon Charitable Pharmacy. I understand my information will be shared with the pharmaceutical companies or their disignee for auditing purposes

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Authorization for Use or Disclosure of Information
From Health Care Providers

I _____ hereby authorize Beacon Charitable Pharmacyand STARK COUNTY JOB AND FAMILY SERVICES to exchange health information and/or disclose the following protected health Information:

RE: _____ Reference Number: _____

Stark County Job and Family Services will verify medical eligibility. This protected health information is being used or disclosed for the following purposes:

For obtaining medications through the Charitable Pharmacy/applying for medications through the manufacturers' medication assistance programs (MAPs).

This authorization shall remain in force and effective until I, the client, notify Beacon Charitable Pharmacy that I no longer need assistance through the Charitable Pharmacy/MAPs.

I understand that I have the right to revoke this authorization in writing, at any time, by sending such written notification to Carol Risaliti at 408- 9th St. SW, Canton, Ohio, 44707. I understand that a revocation is not effective to the extent that Beacon Charitable Pharmacy has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Beacon Charitable Pharmacy will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal or state law.
- Refuse to sign this authorization form.

_____ _____
Name of Client or Personal Representative Signature of Client or Personal Representative

Relationship to Client: _____ _____
Date

For Stark County Job and Family Services Use Only:

STATUS OF APPLICATION FOR ASSISTANCE:

(1) Open For Medicaid: ☐ Effective Date: _____

(2) *Medicaid Family Planning Only* ☐

(3) Is there a spend down? ☐ Amount_____

(4) Medicaid pending: ☐

(5) Not Currently Active in System ☐

SCJFS Staff signature: _____ Date: _____

Comments:

Charitable Pharmacy Donation Program

☑ I. Non-child resistant containers: I understand that all new and refill prescriptions may be dispensed in non-child resistant containers. If I, the signer, am not the patient, I certify that I am authorized by the patient to sign this waiver.

☑ II. Financial Eligibility:

I acknowledge that the information concerning income and expenses has been explained to me and I understand it. I also understand that I have been certified for

☐ One time help ☑ Help for twelve months ☐ Help while in donut hole

☑ III. Review of Patient Records by IPAP-A/IPAPN:

I hereby authorize Beacon Charitable Pharmacy to share any of my information with IPAP-A or IPAP-N, or its designee, including prescription records, in order to coordinate services.

☑ IV. Consent and Right to Revoke Consent:

I understand that I may revoke this consent by contacting Beacon Charitable Pharmacy in writing at any time, except when action has already been taken and/or such information has already been released. My signature on this release indicates I have read the above, or have had it read to me, and that I understand the terms and conditions. I have also had the opportunity to ask any questions. I am signing this release on behalf of my children that are under the age of eighteen (18), if applicable.

☑ V. Ohio Drug Repository Program:

Beacon Charitable Pharmacy has created a drug repository that allows the dispensing of medications that have been donated by extended care facilities. By signing this form I understand that the drug manufacturers, donors, or pharmacy are not responsible for any harm that is caused related to the donation, acceptance, or dispensing of these medications.

I understand the immunity provisions of the Drug Repository Program pursuant to Ohio Revised Code section 3715.872 paragraph (B), which applies to drug manufacturers, donors, and recipients. The immunity provision states that none of these parties shall be "subject to any of the following for matters related to donation, accepting, or dispensing drugs under the program: criminal prosecution; liability in tort or other civil action for injury, death, or loss to person or property; or professional disciplinary actions."

Signature of Client Date

Beacon Charitable Pharmacy Effective January 1, 2010

Beacon Charitable Pharmacy will be charging an

administrative/processing fee for The services provided.

DONATION FEE SCHEDULE

Assistance with one medication/application = $2.00

Assistance with two medications/applications = $4.00

Assistance with three medications/applications = $5.00

We have purchase clopidogrel and are pleased to provide it @ a $4.00 fee

per 30 day supply

Client Signature: _____ Date: _____

Assistance may be applied for through the pharmaceutical companies as necessary also.
No one is denied service if they can not pay.

ACKNOWLEDGMENT OF RECEIPT

I, _____, acknowledge that I have reviewed the Notice of Privacy Practices issued by Beacon Charitable Pharmacy.

I, _____, authorize Beacon Charitable Pharmacy to discuss my health information with participating members of the Network, Pharmaceutical Companies and with the following persons:

Spouse	_____	Children	_____
Parent	_____		_____
	_____		_____
Other	_____		_____
	_____		_____

_____ _____

Date Signature of Patient

Beacon Charitable Pharmacy

Self-Declaration Form

Client Name: _____ **Date:** _____

I hereby attest that;

My household income for the past (12) months has been: _____

My household income for the past (3) months has been: _____

My household income for the current month has been: _____

If household income is/was zero, please briefly explain how your household was maintained for the past three months:

I understand that by signing this form, I authorize the Beacon Charitable Pharmacy or its designated representative's access to public assistance, social security, unemployment, employment or other records needed to verify any statements I have made.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date