St. Vincent de Paul Pharmacy

5750 Pineland Drive, Suite 280
Dallas, TX 75231
(469) 232-9902

Hours: Monday – Friday
8:30am – 4:30pm

Service at St. Vincent de Paul Pharmacy (SVdP)

St. Vincent de Paul Pharmacy provides prescription medication at no cost to residents of North Texas who lack health insurance and who cannot afford to purchase them at a retail pharmacy. If you need medication and you (1) reside in the state of Texas, (2) do not have health insurance coverage of any kind, and (3) meet the income requirements, we may be able to help.

Applying for Service

Each patient of SVdP Pharmacy must apply for service and show that you meet the above criteria. **PLEASE read each page of the intake form carefully and complete each form as completely as possible.**

There are three ways to submit your application:

1. **Print and Complete By Hand**
   Please scan and email to rchavez@svdpdallas.org or gloredo@svdpdallas.org. Or fax to **469-687-9126**.
2. **Download and Complete on Computer**
   Download and SAVE your completed form to your computer. Then attach and email to submit.
3. **Apply by Phone**
   Call during office hours to submit an application if you do not have access to a computer.

Accepted Patient Documents

To complete your application, you must provide one (1) type of documentation from each of the columns below. When submitting your application, remember to attach copies of each document to your email.

Proof of Identity	Residence	Income
Any Identification with the patient's name and photo: 1. Driver's License 2. State Issued I.D. 3. Passport 4. International I.D. 5. School I.D.	Any Mail in the patient's name with their current address: 1. Driver's License 2. State Issued I.D. 3. Mortgage Agreement 4. Contract Lease (Current/Last year) 5. Utility Bill 6. Auto Insurance 7. Treatment Program I.D. as verified by your case manager (can be a letter) 8. Hardship Referral Letter	Proof of Income which covers your monthly expenses, and shows you earn at or less than 300% of the Federal Poverty Level for your household size. 1. Tax return 2. The most recent month's paystubs 3. Letter from employer, detailing wage and hours **If you do not work:** 1. Statements from income source: Social Security, Child Support, Food Stamps, Retirement or Disability 2. Hardship Referral Letter

If you have questions, call the pharmacy at (469) 232-9902 and we can help you!

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Primary Language: _____

Patient Information

Every Patient must complete this form

First Name	MI	Last Name	SSN/ITIN:	Date of Birth (mm/dd/yyyy)

Address	City	State	Zip

Primary Phone #	Gender	Marital Status
	☐ M ☐ F	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity
☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian/White
☐ Native American ☐ Other:

Education Completed
☐ None ☐ Elementary School ☐ High School/GED
☐ 2 Years College ☐ 4 Years College

Employment
☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired
☐ Disabled ☐ Student ☐ Other:

How did you hear about SVdP Pharmacy?
☐ Radio ☐ TV/News ☐ Internet/Website ☐ Church
☐ Other:

# of People in Household: _____ **Please list names and dates of birth for each person living with you:**

_____ _____ _____ _____

_____ _____ _____ _____

Medical and Prescription Information

Health Insurance
☐ None ☐ Medicare ☐ Medicaid ☐ VA Benefits
☐ Other:

In the last 12 months, have you been admitted to the hospital or visited an emergency room for your condition?
☐ Yes ☐ No If yes, how many times? _____

Medication(s) Needed:

Please list Allergies to medications and your reaction:

Patient Income and Expenses

List Household Income:

Salary/Wages	$_____
Disability	$_____
Alimony/Child Support	$_____
Social Security	$_____
Pension/Retirement	$_____
Unemployment/ Work Comp	$_____
Unearned Income	$_____
Gross Monthly Income	**$_____**
Total Gross Annual Income	**$_____**

List Monthly Household Expenses:

Rent/Mortgage	$_____
Utilities (Electricity, Water, etc)	$_____
Food	$_____
Basic Needs (Clothing, Hygiene)	$_____
Total Household Expenses	**$_____**

If someone else pays for your living expenses, please have them complete the Hardship Referral Letter on your behalf.

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Terms of Service Agreement

Every Patient must complete this form. Please read carefully and add your initials to each section. Your initials mean that you have read, understand and agree to each statement.

_____ **Terms of Qualification for Service**
I understand the terms concerning qualification for service at St. Vincent de Paul Pharmacy. I also understand that I have been certified for up to twelve (12) months, and that I must resubmit verification of my qualification for service at the end of that time to continue receiving medications.

_____ **Consent to Treatment by Volunteers**
I understand that services I receive from SVdP Pharmacy may be provided by a volunteer which is not administered for or in expectation of compensation. I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer, including immunity from civil liability for any act or omission resulting in death or injury to a patient.

_____ **Change of Information Agreement**
I acknowledge that I will report any change of address, insurance status or income to SVdP Pharmacy immediately. I understand that any changes may affect my qualification for service at the pharmacy.

_____ **Consent and Release**
I understand that any information I provide to SVdP Pharmacy will be kept confidential. However, I hereby authorize SVdP Pharmacy to share my information, including but not limited to my name, address and other personal information with other medical facilities and/or pharmaceutical manufacturers participating in my care in order to coordinate services. I also authorize SVdP Pharmacy to share my information, including eligibility and prescription records, with any Pharmaceutical Manufacturers Patient Assistance Program(s), or their designee, for which I qualify, for auditing purposes. I understand that this consent is authorized for twelve (12) months from the date signed below, and that I may revoke this consent at any time by submitting a request in writing to SVdP Pharmacy, except when action has already been taken to obtain and/or release such information.

_____ **Permission to Release Information for Patient Assistance Program Qualification**
I also authorize St. Vincent de Paul Pharmacy to use my information, including prescription records, to assist me in finding any Patient Assistance Program(s) for which I qualify, in order to assist me in accessing these programs, and to coordinate services.

I attest that all information submitted in this application is true to the best of my knowledge. By my signature, I indicate that I understand and agree overall to the terms and conditions of service at St. Vincent de Paul Pharmacy. If the patient is a child under the age of 18, I sign as their legal guardian.

Patient's Name Print _____ **Date** _____

Patient's Signature _____ **Date** _____
(Or Signature of legal guardian)