

## 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 do not have 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) have a certain level of income\*\*, we are here to help.

### Applying for Service

Each patient of SVdP Pharmacy must apply for service and show that you meet the above criteria.

**NOTE: We must gather a large amount of information from our patients before providing free medication. PLEASE read each page of the intake form carefully and complete each form as completely as possible. If you have questions, call the pharmacy, or come by and we can help you!**

Below are a list of documents you must provide to apply, along with special notes about the application form.

#### 1. Valid Prescription

If you have a paper copy of a prescription from a doctor, bring it with you to the pharmacy. If your prescription(s) are on file with another pharmacy, you must bring the name, address and phone number of your pharmacy with you, and we will have your prescription transferred electronically.

#### 2. Proof of Residence

To prove your residence is in Texas, you must bring a **Photo ID. If your ID does not have your current address, bring:**

- A utility bill or other official mail showing your name and current address
- If you cannot verify your place of residence, complete the **Homeless Shelter Referral Letter** on page 7.

#### 3. Income Verification\*\*

Staff at the pharmacy will help you determine whether your total household income qualifies you for service. The type of income you receive determines which types of documentation you must submit with your application.

**If you have employment income from a place of work, bring:**

- Last year's tax return, and two (2) most recent pay checks or paystubs.
- If you cannot provide recent pay stubs, bring a letter from your employer, detailing the number of hours you work each pay period and the amount you make per hour.

**If you do not work, but receive income from other sources, bring:**

- Letters or statements which show that you receive payments from sources such as Social Security, Child Support, Food stamps, retirement or disability.
- The **Monthly Income Detail** form on page 4 shows all the types of income recognized by SVdP Pharmacy, and which must be documented in your application.

**If you have no income from a job or any other source, please complete:**

- **Monthly Expenses and Acknowledgement of Support** form on page 6 to account for your cover living expenses.

*If you have no income or you are unsure how to verify your income, please call the pharmacy at (469) 232-9902.*

**Please bring your documents and completed intake application form with you to SVdP pharmacy. IF you are unable to submit your application in person, please call the pharmacy to make other arrangements.**

## Patient Information

Every patient must complete this form.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender  Male  Female

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Age Range:  0-17  18-29  30-49  50-64  65+

Race/Ethnicity  African American  Asian  Hispanic  Native American  White  Other \_\_\_\_\_

Primary Language \_\_\_\_\_ Interpreter Needed?  Yes  No

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 \_\_\_\_\_

Are you a Veteran?  Yes  No Do you have a Case Manager?  Yes  No

If you have a case manager or someone referred you, please list the name of the individual and/or organization:

\_\_\_\_\_

Marital Status  Single  Married  Separated  Divorced  Widowed

### Spouse Information (if applicable)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender  Male  Female

Employment  Full-Time  Part-Time  Temp  Unemployed  Retired  Disabled  Student  Other \_\_\_\_\_

Is your spouse a veteran?  Yes  No

### Other Household Member Information

Total # in Household (including patient): \_\_\_\_\_

Please use back of page to detail additional family members.

Name	Gender (M/F)	Age	Relationship

**Medical and Prescription Information**

**Health Insurance**  Medicare  Medicaid  VA Benefits  Other \_\_\_\_\_  None

**Please list Medication(s) Needed:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any Allergies to medications and your reaction:** \_\_\_\_\_  
\_\_\_\_\_

**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? \_\_\_\_\_

**How did you hear about SVdP Pharmacy?**  Radio  TV/News  Internet/Website  Church [Give Name, if possible]: \_\_\_\_\_  Other \_\_\_\_\_

**Consent to Treatment by Volunteers**

*Please read carefully and add your signature below.*

I understand that services I receive from St. Vincent de Paul Pharmacy may be provided by a volunteer who is providing care that 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 in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

- 1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
- 2) The volunteer commits the act or omission in the course of providing health care services to the patient.

**I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.**

( ) Myself

( ) The following person for whom I am legally responsible: \_\_\_\_\_

**Print Patient's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

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

## Monthly Income Detail

Every patient must complete this form. If you are unsure how to complete, pharmacy staff can help you.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

Name of Employer \_\_\_\_\_  Unemployed

Wage Amount: \_\_\_\_\_ Wage Frequency:  Hourly  Daily  Weekly  Monthly  Yearly

Total Monthly Income from Other Wage Earners (spouse) In Household: \_\_\_\_\_

### Income from Other Sources

In order to verify your total annual household income, we must account for all types of income received. Apart from hourly wages or a salary from a place of employment, please detail any payments received from any of the following sources:

- Tips,
- Unemployment benefits,
- Social Security benefits,
- Welfare benefits,
- Disability, worker's compensation, or other payments for an injury or illness,
- Retirement or Pension benefits,
- Alimony or Child Support payments,
- Annuity or Life Insurance payments,
- Interest or Dividends from savings accounts or Investments, or any withdrawals from these accounts,
- Rental Income or income from your business,
- Income from Royalties, Patents, Gambling or Lottery winnings.

If possible, you must also provide documentation which shows you receive this income, or a copy of your bank statement which can show these payments. You may provide another blank sheet to detail additional income.

Source/Organization	Monthly Amount Paid

If you do not receive income from employment or from any of the sources above, please complete the Monthly Expenses and Acknowledgement of Support form on page 7 to detail how you cover your monthly living expenses.

Total monthly household income: \_\_\_\_\_ Total annual household income: \_\_\_\_\_

(Total monthly household income = Patient's monthly wages + income from other wage earners (spouse) + income from other sources)

#### OFFICE USE ONLY

I have reviewed this income section with the applicant and verified their total annual household income.

Intake Screener Signature \_\_\_\_\_ Date \_\_\_\_\_

## 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 acknowledge that the terms concerning qualification for service at St. Vincent de Paul Pharmacy have been explained to me and I understand them. I also understand that I have been certified for up to twelve (12) months, and I understand that re-verification of qualification for service at the Pharmacy is needed to continue receiving medications beyond that date.

\_\_\_\_\_ **Change of Information Agreement**

I attest to the above information as true to the best of my knowledge, and will report any change of my address, my insurance status or income to SVdP Pharmacy immediately. I understand that any of these 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.

By my signature, I indicate that I 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)

## Monthly Expenses and Acknowledgement of Support

Please complete this form if you are not employed, have no income, and someone else helps to cover your living expenses. If you are employed and able to verify your income, you do not need to complete this section.

### Monthly Expenses

Please detail the monthly cost of each of the following monthly expenses, and how you cover them. You do not have to detail exactly how much, but estimate within a few dollars.

Expense	Monthly Amount	Payment Source (Individual/Agency Who Pays)
Rent/Mortgage		
Utilities (electricity, water, etc)		
Food		
Clothing, hygiene, basic needs		

### To Be Completed by Individual or Organization/Agency assisting the Applicant:

If the person supporting is an individual:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_

Relationship: \_\_\_\_\_ Do you pay the expense yourself?  Yes  No

If the support comes from an organization/agency:

Organization Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Contact Name (First, Last) \_\_\_\_\_ Title \_\_\_\_\_

Is the payment given directly to the applicant?  Yes  No

Other Notes \_\_\_\_\_

By my signature, I attest that this applicant has no income or insufficient income and that I, or the organization I represent, provide(s) financial support for their living expenses. The information provided above is accurate, complete and true to the best of my knowledge.

Supporter Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Or Signature of legal guardian)

## Homeless Shelter Referral Letter

*Please complete this form if you are homeless or otherwise unable to verify your place of residence. This letter must be completed by the individual, organization or advocate who provides housing support for you.*

RE: St. Vincent de Paul Pharmacy:

For (Applicant Name): \_\_\_\_\_

To Whom It May Concern,

This letter is to verify that \_\_\_\_\_ is homeless, as defined below (please choose one):

- An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:
- A. *An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport or camping ground; or*
  - B. *An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations, or by federal, state, or local government programs for low-income individuals); or*
  - C. *An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.*

An individual or family who are fleeing, or are attempting to flee domestic violence, dating violence, sexual assault, stalking or other dangers or life-threatening conditions that relate to violence against the individual or a family member.

Their current income is \_\_\_\_\_  Hourly  Daily  Weekly  Monthly  Yearly,

And their income source is \_\_\_\_\_. This letter verifies that the individual named above needs shelter/supportive housing. Please let us know if you require additional information regarding this individual or family.

Sincerely,

Individual/Organization Name \_\_\_\_\_

Title/Relationship \_\_\_\_\_

Email \_\_\_\_\_ Phone \_\_\_\_\_

Date \_\_\_\_\_