Prescription Assistance Program of Ohio
Instructions

1. **Sign and date where indicate on all three forms**

2. **Return to:**

   Prescription Assistance Program of Ohio
   7757 Auburn Road, Suite 6
   Concord Twp., Ohio, 44077
   or
   Fax to: 440-350-1471

3. **There is no charge for the prescription medicine. You will only be billed for handing and postage which is currently $6.00 per prescription. If writing a check, make it payable to: Prescription Assistance Program of Ohio.**

4. **For refills**
   a. **Call 440-350-1470 and leave a message with your name, phone number and prescription number**

   b. **Fax to 440-350-1471**

   c. **Mail to 7757 Auburn Road, Suite 6, Concord Twp., Ohio 44077**

Any Questions Please Call:
Dawn Nickerson
440-350-1470

The clinic does not operate ever day of the week. Please leave a message if you get the voice mail.

Prescription Assistance Program of Ohio

Enrollment Information Form

1. Based on the number in your household are you at or below the income indicated.

Circle Yes or No

Persons in Household	Families/households with more than 8 persons, add $5,530 for each additional person. The income below is three times the Federal Poverty Guidelines
1	$46,800
2	$63,390
3	$79,980
4	$96,570
5	$113,160
6	$129,750
7	$146,340
8	$162,930

2. Are you a resident of the State of Ohio? If requested can you prove it by a picture ID?
Circle Yes or No

3. Do have insurance that pays all or part of the cost of your prescription medicine?
Circle Yes or No

4. If you have insurance that pays a part of you prescription medicine can you afford the co-pay?
Circle Yes or No

First Name:_____ Last Name_____

Address: _____

City_____ County_____

Zip Code _____ Phone Number_____

Date of Birth_____ Email Address_____

Your Signature_____ Date _____

Office Information:

Date Mailed:_____ Date entered into computer_____

Return to: Prescription Assistance Program of Ohio- 7757 Auburn Road, Suite 6 Concord Twp., Ohio 44077

Prescription Assistance Program
Authorization, Documentation and Prescription Information

1. I authorize the Prescription Assistance Program to contact my physician if the prescribed medications are not in stock in the pharmacy of the Prescription Assistance Program for a suitable substitution.

2. The information I have provided to the Prescription Assistance Program is accurate to the best of my knowledge

_____ _____
Patient/Caregiver/POA/Guardian Signature Date signed

Medication List you are requesting to be filled

Clients Name: _____

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

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Food and Drug Allergies

1. Do you have any drug or food allergies: Please circle **Yes or NO**
2. If yes, please list all allergies below:

Immunity

I understand the immunity provision of the Prescription Assistance Program pursuant to the Ohio Revised Code Section 3715.872 Paragraph (B) which applies to drug manufactures, donors. Recipients, and those who dispenses drugs under the program. The immunity provision states that none of these parties shall be subject to any of the following for matters related to donating, 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 of professional disciplinary action.

Signature_____ Date _____

Prescription Assistance Program
Contact Information for Client

_____ _____
First Name Last Name

_____
Street Address

_____ _____ _____
City County Zip Code

_____ _____
Phone Number Email Address

_____
Clients Date of Birth

Contact name other than clients_____

Date application was completed_____

How did you learn about the Prescription Assistance Program?

_____My Health Caregiver
_____News media (newspaper, radio, television)
_____A family member, friend or neighbor
_____A community organization (Senior Center, Free Clinic, Human Services, etc.)

Other, please explain: _____

The Prescription Assistance Program of Ohio is a non-profit corporation. The primary area of service is Lake, Ashtabula and Geauga Counties. However any Ohio resident may make application to the prescription assistance program.

The medicine within the inventory changes on a monthly basis. By Law, no controlled substances are handled by the program. Individuals using the services of the program must not use the program as their only source of their prescription medicine.

Any Question Please Call: Dawn Nickerson at 440-350-1470