



**Charitable Pharmacy
of Hope Clinic
of Ross County, Inc.**

610 Central Center
Chillicothe, OH 45601
Phone: 740-672-2095
Fax: 740-672-2096

Cert Date: _____

PAP Eligible: Y or N

Recert Date: _____

Copied: ID & INS (if applicable)

Entered in QS/1: Y or N

PATIENT INFORMATION

Last name _____ First name _____ Date of Birth _____

Gender ☐ Male ☐ Female ☐ Undefined US Resident ☐ Yes ☐ No Race/ Ethnicity _____ Language _____

Proof of Identification (only 1): MAKE COPY

☐ Driver's License/State ID ☐ Passport ☐ Signed Affidavit ☐ Other: _____

Medical Information

Allergies _____

Prescription Insurance: ☐ Uninsured ☐ Medicare Part D ☐ Private **MAKE COPY**

What chronic health conditions do you have? ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Depression ☐ Anxiety ☐ Bipolar

☐ Asthma ☐ COPD ☐ Other _____

What medications do you take? _____

Do you need any prescriptions transferred to the Charitable Pharmacy? **Yes or No**

If "yes", from where? _____

HEALTHCARE ACCESS

☐ No ☐ Yes Have you been to an emergency room or urgent care in the past 12 months?

If "yes", how many times? _____

☐ No ☐ Yes Have you been admitted to a hospital in the past 12 months?

If "yes", how many times? _____

☐ No ☐ Yes Do you have a primary care doctor who can prescribe your medications?

☐ All ☐ Some How many of your prescribed medications do you fill?

☐ None

FOOD SECURITY

Adapted from The Hunger Vital
Risk™

☐ No ☐ Yes In the past 30 days, did you worry your food would run out before you got money to buy more?

☐ No ☐ Yes In the past 30 days, did you run out of food without money to buy more?

If "yes" to EITHER, refer patient to Mobile Market

☐ Referred

Charitable Pharmacy of Hope Clinic – Acknowledgement, Consent and Release

With the exception of certain limited circumstances, it is the policy of Hope Clinic not to release personal information about you or your family without the written consent of the individual or the family. Therefore, we need your written consent to share your information in order to provide services to you and/or your family in the most expeditious and least cumbersome manner:

Information & Use: I hereby authorize Hope Clinic to share any of my information, including but not limited to my name, address, and other personal information, with other medical facilities, social service organizations, and/or pharmaceutical manufacturers participating in my care in order to coordinate services. I also authorize Hope Clinic to enter my personal information into a secure database for statistical purposes. All other information will remain confidential.

Terms of Consent: I understand that this consent is authorized for 365 days (12 months) from the date signed below, and that I may revoke this consent by submitting a request in writing to Hope Clinic at any time except when action has already been taken to obtain and/or release such information. 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. If applicable, I am also signing this release on behalf of my children that are under the age of eighteen (18).

Collaborative Practice: I understand that the Charitable Pharmacy of Hope Clinic may enter into a collaborative practice agreement with my physician for the purpose of managing my drug therapy. As allowed by the state of Ohio (pursuant to ORC4729.39) and my physician, I consent to allow pharmacists to manage my drug therapy when appropriate as indicated by my signature below. I understand my right to opt out of this program at any time by providing withdrawal of consent in writing.

Non Child-Resistant Containers: I acknowledge that Hope Clinic may dispense prescription medications in containers that are not child-resistant based on available supplies.

Drug Repository: Hope Clinic has created a Drug Repository that allows the dispensing of medications that were donated from Long-Term Care facilities. Your signature on this form means that you understand that, if you receive medications from this Drug Repository, neither the drug manufacturers nor the donors nor the recipient is 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 apply to drug manufacturers, donors, and recipients. The immunity provisions state 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 action.”

Donation of Unused Medications: I understand that I am not permitted to donate or return any medication once it has been removed from a pharmacist’s supervision. If medication from a Drug Manufacturer Patient Assistance Program is mailed to the pharmacy in my name, and I choose not to utilize this medication either from a doctor’s discontinuation order or my departure from the Charitable Pharmacy program, I agree to donate any such medication to Hope Clinic for the purpose of helping another person in need. I authorize a Hope Clinic representative to complete any Patient Assistant Program application on my behalf.

Attestation of Eligibility Determination: I acknowledge that the information concerning eligibility has been explained to me, and I verify the above information is true. I also understand that I have been certified for the time period listed above. I will report any changes of my insurance status or significant change in income to Hope Clinic immediately. If I have been deemed eligible for Patient Assistance Programs, I hereby authorize Hope Clinic to share any of my information, including prescription records, with the programs for which I qualify, and their designee(s), in order to coordinate services. I understand that I may revoke this consent at any time if done so in writing except when action has already been taken to obtain and/or release such information. My signature on this release indicates that 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. If applicable, I am signing this release on behalf of my children that are under the age of eighteen (18). If I, the signer, am not the patient, I certify that I have been authorized by the patient to sign this waiver.

Attestation of Accuracy: I attest that the information I have reported in these certification documents is accurate to the best of my ability.

Patient Name (print): _____

Patient Signature: _____ **Date:** _____

ELIGIBILITY ATTESTATION

Applicant Name _____ DOB _____

PART 1: Participant Income Information

- I hereby attest that my current estimated annual income from wages is \$ _____
- Additional income sources such as social security disability income, workers compensation benefits, dividends, interest, assistance from family, friends or charity, public assistance and/or food stamps or other sources: \$ _____
- Those other sources of income are: _____
- Income for all others living in my household during the same 12-month period \$ _____
- Number of individuals in my household _____
- Total income from wages and all other sources \$ _____

PART 2: Insurance Information

_____ I hereby attest that I am not covered by any form of prescription insurance *including Medicare, Medicaid, VA benefits or other coverage*

*****OR*****

_____ I have insurance that covers prescriptions, but I am unable to afford the out-of-pocket expenses. **Please bring your insurance card with you.**

PART 3: SIGNATURE (required)

I certify that all of the above information is true and accurate. I understand that this information is to be used to determine my eligibility for different medication access sites utilized by the Charitable Pharmacy of Hope Clinic. I will notify staff of any changes in employment, income or insurance prior to having additional prescriptions filled.

Applicant Signature _____ Date _____

Staff Signature _____ Date _____

FOR PHARMACY USE ONLY: Please compare the total income in Part 1 above with the 2024 Federal Poverty Guidelines below. Applicants must be at or below 300 % of FPG. They must also either lack insurance or be covered under a plan with no prescription coverage (=YES). Patients with Medicaid, Medicare, VA benefits, or other coverage are not eligible for Dispensary of Hope/PAP medications, but they do qualify for donated and purchased medications (=NO). www.nedymeds.org/fpl_calculator

Calculated FPL: _____

2025 Poverty Guidelines for the 48 Contiguous States and the District of Columbia Effective 1/2025

| Persons in family/household | Poverty Guideline | 300% Federal Poverty Guideline |
|-----------------------------|-------------------|--------------------------------|
| 1 | \$15,650 | \$46,950 |
| 2 | \$21,150 | \$63,450 |
| 3 | \$26,650 | \$79,950 |
| 4 | \$32,150 | \$96,450 |
| 5 | \$37,650 | \$112,950 |
| 6 | \$43,150 | \$129,450 |
| 7 | \$48,650 | \$145,950 |
| 8 | \$54,150 | \$162,450 |

For families/households with more than 8 persons, add \$5,500 per person.

ELIGIBILITY = YES (Access to all meds=uninsured) or **NO** (access to meds limited due to INS)

CIRCLE ONE