NewYork-Presbyterian
Ambulatory Care Network

Pharmacy Assistance Program
622 West 168th Street
VC 10, Area C, Room 3
New York, N.Y. 10032
Tel: (212) 342-1617

ENROLLMENT FORM

Patient

Name (Please Print Clearly) __________________________ __________________________
Last First

Address: ____
No Street Apt. #

____
City State Zip code

Telephone Number: ____ -_____ - ______________ (*To call you when the medication arrives)*

Alternate Number: ____ -_____ - _______________

Date of Birth: ________________ Social Security Number _______ - ____ - _________
Month/Day/Year

Marital Status (circle one): single married divorced separated widowed

Sex (circle one): male female

Primary Insurance: ______________________

Prescription Plan or Prescription Card (if any): ________ Are you in the Epic Program: _______

Source of Income: ☐ Wage ☐ Support by Family ☐ Alimony ☐ Pension
(Check one): ☐ Social Security Retirement ☐ Social Security Disability ☐ None
☐ Other: _____________________

Monthly Household Income: $___________________ Household Size: _______________

Are you a veteran? ☐ No ☐ Yes Are you disabled? ☐ No ☐ Yes

Ethnic Origin (circle) African-American Asian Native American Hispanic White
Other

Any known allergies: ____

Chronic condition: ____

Enrollment Facilitator

Name of Person helping fill out application____

Title/Relationship to Applicant____

Phone Number _____________________ E-mail____________________________________

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I, ________________________ consent to be enrolled in the Pharmacy Assistance Program
(Print Name)
I understand the nature of the Pharmacy Assistance Program and will adhere to the list of patient responsibilities that I was given.

By signing this consent I authorize ACN-PAP staff to share with the pharmaceutical manufacturers the information I provided on this form for the sole purpose of obtaining my medication through their Patient Assistance Program. I am aware that in the case that medications that are ordered for me through ACN-PAP are not collected within 90 days of being received by the participating pharmacy, ACN-PAP is not responsible for the distribution of said medications. In such a case, a new application must be generated.

I also understand that ACN-PAP requires proof of income or a statement of benefits to provide verification for eligibility and by signing this consent I give permission to ACN-PAP to obtain this proof of income or statement of benefits from my health care provider or community health facility.

Furthermore I authorize the coordinator for the ACN-PAP program to sign and date all documentation/forms that are sent to any of the participating pharmaceutical companies on my behalf. The role of ACN-PAP shall be limited to administrative functions and signatory power in reference to eligibility forms that are submitted to the participating pharmaceutical companies for prescription medication.

I understand that by signing this consent form does not automatically qualify me to receive prescription medications from the participating pharmaceutical companies, which have their own guidelines.

_________________________________ ____________
(Patient Signature) Date

Please initial over the appropriate box: (These are not conditions for participation)

- ☐ I permit my Provider to discuss any improvement of my health status as a result of my participation in this program
- ☐ I agree to participate in surveys regarding my experience with the Pharmacy Assistance Program conducted by Ambulatory Care Network Community Health Outreach.

All information will be used solely for the purpose of improving the quality of the Pharmacy Assistance Program

____
Date

PLEASE BE SURE TO INCLUDE:

1. An original prescription for the brand name medication
2. Proof of income
3. Copy of Medicare card (if applicable)

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Patient Responsibilities

- *Must **fully** complete application*
- *Request **original** prescriptions from physician*
- *Copy of Medicare Card (if applicable)*
- *Provide proof of income:*
    - *Social Security Statement, Pension, Worker's Comp.*
      Or
    - *Bi-weekly pay (2 pay stubs), weekly pay (3 or 4 pay stubs)*
      Or
    - *Award letters*
      Or
    - *Support letter*

- *If you do not have proof of income, please obtain any of the documents listed above from the individual who is supporting you.*

- *When you only have **30 days** of your medications, you should contact your physician or social worker and request **two** new original prescriptions, one will be sent to ACN-PAP and the other one will be sent to you. ACN-PAP **must** order patients' refills; **the pharmacy cannot fill refill request.***

PLEASE GIVE THIS DOCUMENT TO THE PATIENT, THANK YOU.