Brunswick Senior Resources, Inc. (BSRI)

Prescription Assistance Program through Manufacturers

Many state and corporate prescription assistance programs help patients obtain free or low-cost medications if they qualify. To find out if you qualify for these programs, complete the application to be matched to programs for which you may qualify. Please remember BSRI's program is an information and assistance resource. We will provide assistance in applying to the programs directly to obtain free or low-cost medications.

Documentation Requirements

****CHECK BOX THAT APPLIES TO YOU****

☐ **If you are 65 and older and/or disabled with Medicare, check this box and turn to page 2 for special instructions.**

☐ **If you are recently disabled/early retirement but receive NO Medicare benefits, check this box.**

1. **Proof of Income**—For yourself and spouse *(if married)*
   Examples include a bank statement showing direct deposit of Social Security check, tax return, or retirement benefit letter showing amount. (NO COPIES OF SOCIAL SECURITY CHECK)
2. **Medicaid Denial Letter or Inquiry (if you have applied)**
3. **Copy of insurance card front and back (if you have insurance)**

☐ **If you are employed with or without prescription coverage, check this box.**

1. **Proof of Income**—At least one month consecutive paycheck stub(s) and a copy of your tax return are required. (Most recent for both documents)
2. **Copy of Identification**
3. **Medicaid Denial Letter or Inquiry (if you have applied).**
4. **Copy of insurance card front and back (if you have insurance)**

☐ **If you are unemployed, check this box.**

1. **Proof of Income from Head of Household**—If there is no income for the entire household, you need a notarized letter explaining the circumstances and a list of the charity contributions you are receiving. If you are living on past earnings, please include a bank statement.
2. **Copy of Identification**
3. **Medicaid Denial Letter or Inquiry (if you have applied)**
4. **Copy of insurance card front and back (if you have insurance)**

If you have any questions about documentation requirements, please call PAC. The PAC's contact information is provided on Page 7.

If you are 65 and older and/or disabled with Medicare, follow the instructions listed below. If you are not, continue to page 3.

☐ **If you are enrolled in a Medicare D or Medicare Advantage (C) plan, check this box.** Please provide all documents required in this section. You must call PAC to set up an appointment. Application must be complete and **all** documentation must be provided at the appointment.

1. **Proof of Income**—For yourself and spouse *(if married)*
   Examples include a bank statement showing direct deposit of Social Security check, tax return, or retirement benefit letter showing amount.
2. **Copy of Medicare Card**
3. **Copy of Medicare D or Medicare Advantage (C) Card (front and back)**
4. **Copy of Denial Letter from Social Security Subsidy Application Submission**
   The manufacturers are requesting this denial letter in order to receive free meds. You must submit an application even if it is obvious you exceed the income qualifications. You may call (910) 754-6559 to apply. If you do not qualify, a letter of denial will be sent to you. If you misplaced the denial, please contact the Social Security Administration office at (800) 772-1213 for a reprint.
5. **Explanation of Benefits' Statement (EOB) from your Medicare D or Medicare Advantage (C) plan and/or an Out-of-Pocket Statement from a Local Pharmacy**
   The EOB is a statement you receive quarterly showing the total amount you have spent on prescriptions.

☐ **If you are NOT enrolled in a Medicare D or Medicare Advantage (C) plan:** Please provide all documents required in this section.

1. **Proof of Income**—For yourself and spouse *(if married)*
   Examples include a bank statement showing direct deposit of Social Security check, tax return, or retirement benefit letter showing amount.
2. **Copy of Medicare Card**
3. **Copy of Denial Letter from Social Security Subsidy Application Submission**
   The manufacturers are requesting this denial letter in order to receive free meds. You must submit an application even if it is obvious you exceed the income qualifications. You may call (910) 754-6559 to apply. If you do not qualify, a letter of denial will be sent to you. If you misplaced the denial, please contact the Social Security Administration office at (800) 772-1213 for a reprint.
4. **A brief statement explaining the reason for not enrolling in a Medicare D or Medicare Advantage (C) plan**

Prescription Assistance Application

Participant Information Form

Date: _____ **Name:** _____

Address: (P.O. Box and Physical) _____

_____

Phone Number: _____ **# of People in Home:** _____

Date of Birth: _____ **Marital Status:** _____ **Spouse's Name:** _____

Social Security Number: _____ ○ **Male** ○ **Female**

Monthly Household Income: _____

Source: ○ **Social Security** ○ **SSI** ○ **Pension** ○ **Unemployment** ○ **Wages**
○ **Disability or Retirement** ○ **Other**_____

Do you have Prescription Insurance? ○**Yes** ○**No** **Primary Physician:** _____

Please list any allergies: _____

Please list medical conditions: Heart COPD Glaucoma Diabetes Renal Failure

Other: _____

Current Medications:

Name/ Dosage (mg, times per day)	**Name of Prescribing Doctor**

If you need more space, please use the back of this page.

Brunswick Senior Resources, Inc.
Prescription Assistance Program
P.O. Box 2470
Shallotte, NC 28459
(910) 754-2300

Limited Power of Attorney

I, (Print Name)_____, appoint Marilou Smith, agent of the Brunswick Senior Resources Inc. Prescription Assistance Program (BSRI-PAP), to be my attorney-in-fact, to sign applications and letters for me for the purpose of obtaining prescription medications for me at low cost or no cost through pharmaceutical manufacturers' prescription assistance programs. This power of attorney will be valid until termination of the program initiated by the participant in writing.

_____ Date _____

Participant's Signature

_____ Date _____

Marilou Smith, PAC Signature

Brunswick Senior Resources, Inc.
Prescription Assistance Program
P.O. Box 2470
Shallotte, NC 28459

AUTHORIZATION FOR RELEASE OF INFORMATION

In order to provide you with the services of the Brunswick Senior Resources Inc. Prescription Assistance Program (BSRI-PAP), it is necessary that certain persons have access to the information that you give to us. Please read the following carefully, and if you agree, authorize your consent by signing at the bottom of the page.

I authorize the BSRI-PAP staff, contractors, agents and volunteers to use the information that I am providing as part of the patient evaluation process to assist in the completion of my medication management assessment and the applications for prescription assistance programs for which I may be eligible.

I authorize the release of my patient evaluation information to any BSRI staff and/or volunteer(s) for the purpose of determining any other resources available to enhance my wellbeing and quality of life.

I authorize the release of my patient evaluation information to my physician for the purpose of determining whether there are any changes necessary in my medications or health care.

I authorize from my physician the release of my patient information to the BSRI-PAP for the purpose of determining whether there are any changes necessary in my medications or health care.

I authorize the agents and contractors of the North Carolina Office of Research, Demonstrations, and Rural Health Development and its partner organizations to have access to my medical and financial information for the purposes of administering and evaluating this program.

I understand that the information that I provide will be considered confidential and will only be used for the purposes and by the entities noted above.

Name: _____

Signature: _____ Date: _____

PARTICIPANT'S CONTRACT

We will do our best to evaluate your medication needs and help you obtain your medications at the lowest possible cost, but we need your cooperation. As partners in this effort, it is important you understand and agree to the following requirements.

You must notify your Prescription Assistance Coordinator (PAC) within five days of receiving medications. Please leave your name, medication name, strength and quantity received on PAC's voicemail. Failure to do so will affect the days you will be without medications before a reorder arrives at your physician's office. All documents received from the manufacturers must be mailed to your PAC.

If there is any change in your prescriptions, you must notify your PAC immediately. Failure to do so will affect the time you will be without medications before reorder or new medications arrive at your physician's office.

All medications will arrive at your physician's office and you will be notified for pick up. Only a few manufacturers mail to a patient's home and that decision is not influenced by a hardship or preference. If there is a change in physician(s), you must notify your PAC immediately. A change in physician may affect the medications you are receiving through the PAP program and the schedule for receiving them.

If there is a change in your income, address, phone number, and/or employment, you must notify your PAC.

If you become eligible for programs that pay for your medications, you must notify your PAC. It is against the law to willfully withhold information or make false statements. You may be held accountable to the manufacturers for the cost of medication.

If at any time you decide to terminate your participation in the program or relocate to another county, you must notify your PAC.

Rude behavior of any nature will not be tolerated. This is a voluntary program and the PAC can terminate your participation in the program at any time due to behavior and/or noncompliance of participant contract.

BSRI is a non-profit organization and is not held liable for the program being unable to fill all prescription needs. You should always be prepared financially to cover the cost of your medications at any time. You remain responsible for following up on the information required by the manufacturers' program guidelines.

Participant Signature: _____ Date: _____

Thank you for your interest in the BSRI Prescription Assistance Program offered to ages sixty (60) and older. The PAC may extend the program to those under the age of sixty (60) if there is a special need and/or resources are available. Please remember, this is a senior resource and seniors have priority. If you have any questions, please feel free to call me.

Checklist:

Required documentation (Page 1)
Prescription Assistance Application (Page 3)
Limited Power of Attorney (Page 4)
Authorization for Release of Information (Page 5)
Participant Contract (Page 6)

You may mail, fax or email the application with the required documentation. If you are enrolled in a Medicare D plan, you must call for an appointment.

It may take up to three months before the medications arrive at your physician's office.

PLEASE TEAR BELOW FOR YOUR RECORDS

Marilou Smith, Prescription Assistance Coordinator & SHIIP Co-Coordinator
BSRI-PAP
PO Box 2470
Shallotte, NC 28459

(910) 754-6559
(910) 371-9823 - Fax
Email: msmith@bsrinc.org

PAC Office Hours: (Appointment Only)
Monday-Friday: 8am-4pm
Exception: The first and third Tuesdays of each month, I am out of the office all day for a physician's route.

Please Visit our Website: www.bsrinc.org

PARTICIPANT'S CONTRACT (Participant's Copy)

We will do our best to evaluate your medication needs and help you obtain your medications at the lowest possible cost, but we need your cooperation. As partners in this effort, it is important you understand and agree to the following requirements.

You must notify your Prescription Assistance Coordinator (PAC) within five days of receiving medications. Please leave your name, medication name, strength and quantity received on PAC's voicemail. Failure to do so will affect the days you will be without medications before a reorder arrives at your physician's office. All documents received from the manufacturers must be mailed to your PAC.

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All medications will arrive at your physician's office and you will be notified for pick up. Only a few manufacturers mail to a patient's home and that decision is not influenced by a hardship or preference. If there is a change in physician(s), you must notify your PAC immediately. A change in physician may affect the medications you are receiving through the PAP program and the schedule for receiving them.

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****Note: It may take up to three months to receive your first 90 days' supply of medication. The medication will arrive at the doctor's office that prescribed the medication. We have NO emergency funding to assist with costs until then.**

Social Needs Screening Tool

Please answer the following questions to help us better understand you and your needs. We want to make sure that you are aware of all the community resources available to you. If you check the box to receive assistance, a BSRI Case Manager will contact you within 48 hours once your application is received.

Name: _____ **Phone Number:** _____

Preferred Language: _____ **Best time to call:** _____

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	
	Are you worried that in the next 2 months, you **may not have stable housing?**	
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	
	Do you ever need help **reading hospital materials?**	
	Are you **afraid you might be hurt** in your apartment building or house?	
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	