

WV Health Right Patient Eligibility Form 2009

Form Completed _____ Date _____ Initials _____
 POI Told _____ Date _____ Initials _____
 IRS Form _____ Date _____ Initials _____
 POI Rec'd 2009 _____ Date _____ Initials _____
 PHOTO ID _____ Date _____ Initials _____
 REFERRAL: If yes, from Where?: _____
 WVRx, clinic, doctor, etc.
 CAP Car _____

NAME _____
 Last First Middle Initial Maiden Name

ADDRESS _____
 Street Address or PO Box

City County State Zip Code

PHONE _____
 Include Area Codes Home Work Cell

EMAIL ADDRESS _____

NEAREST RELATIVE OR FRIEND'S PHONE # _____

BIRTH DATE: _____

SOCIAL SECURITY # _____

Are you employed? YES NO
If YES, Where? _____

Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian	Homeless Status <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Living with a friend or relative	Medical Insurance Status _____ No Insurance _____ Medicaid (white card from the State of WV) _____ Veterans (V.A.) _____ Private Ins: _____ _____ Medicare _____ Medicare Part D status: _____
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DRUG ALLERGIES? YES NO
If YES, LIST:


Do you have a regular doctor? If yes, who? YES NO

 Physician's Name

Have you been to an ER in past yr? YES NO
If YES, # of times to the ER: _____
If YES, Name of Hospital ER: _____

IMPORTANT: The section below deals with TOTAL Household information, proof of income must be provided annually and this form updated annually. Last Grade of School Completed: _____

of People in the household: _____ **WITHOUT this clinic, what would your medications cost you monthly:** \$ _____

List the full name & age of ALL house members and their income if employed.	Age	Wages	Social Sec. Disability	Retirement	Workers Comp/	Veterans/ & Other	TOTAL
Your Information 		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
Total Household income		\$	\$	\$	\$	\$	\$

PATIENT AGREEMENT / DISCLOSURE I agree to allow WV Health Right to complete any patient assistance program enrollment process on my behalf, which may include disclosure of personal and medical information necessary to determine eligibility for available drug manufacturer programs to secure my prescribed medication. Your information is confidential and secure, and only available to licensed prescribers, WV Health Right pharmacy staff and Administrative staff. By signing this form I attest that this information is true and accurate. I also agree that if I enroll with any medical insurer (including but not limited to Medicaid & Medicare programs) or if my financial situation changes that I will immediately notify WV Health Right. I also agree to allow pharmaceutical company auditors to review my information as needed for participation in patient assistance programs.

Form Updated 02/09 tfm _____
 Signature Date