

# WV Health Right Patient Eligibility Form 2010

Form Completed \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_  
 POI Told \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_  
 IRS Form \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_  
 POI Rec'd 2010 \_\_\_\_\_ 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?** \_\_\_\_\_

<b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Race</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian	<b>Homeless Status</b> <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Living with a friend or relative	<b>Medical Insurance Status</b> _____ 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
<b>Your Information</b> →		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
<b>Total Household income</b>		\$	\$	\$	\$	\$	\$

**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 12/09 tfm

\_\_\_\_\_  
 Signature Date