Reedsburg AREA MEDICAL CENTER

Medication Assistance Program

The Medication Assistance Program is offered by Reedsburg Area Medical and is intended to allow individuals access to outpatient medications at a reduced cost who are unable or have limited ability to pay for these medications.

What does the Medication Assistance Program Cover?

□ The Medication Assistance Program allows eligible persons to receive certain outpatient medications for $1 (generic drugs) or $3 (brand drugs) per month

□ There are over 100 medications that are covered under the Medication Assistance Program

Who is eligible?

□ Have one of the insurance coverage circumstances outlined below

- □ No prescription drug coverage or you have Medicare Part D
- □ Not enough coverage to obtain the medication with monthly prescription medication out of pocket expenses exceeding $100.00
- □ Your insurance denied coverage for the requested medication. Please include the denial documentation.

□ You have an established relationship with a Reedsburg Area Medical Center provider

□ Total household income is at or below 400% of the 2023 Federal Poverty Level (FPL) Guidelines. See www.aspe.hhs.gov/poverty for more information.

What information is needed to submit an application?

□ Entire completion of this application and sign and date Patient Authorization to Share Health Information in section 5 and Patient Certification in section 6

□ Provide information about your family's gross monthly income (income before taxes and deductions)

□ Provide documentation for family income

If you have questions or need help completing this application: call 608-524-6487 and ask for Financial Counselors. You may maintain help for any reason, including disability and language assistance.

Mail completed application with all documentation to:

Reedsburg Area Medical Center
Attn: Pharmacy
1900 N Dewey Ave.
Reedsburg, WI 53959

To submit your completed application in person: drop off the completed application with all applications at the same address listed above at the north or south registration desk.

What happens next?

□ We will notify you of the financial determination of eligibility within 15 business days of receiving a complete financial assistance application, including documentation of income.

□ You will be enrolled for 12 months. Medicare Part D patients are enrolled through the end of each calendar year.

Please note: We cannot guarantee that you will qualify for financial assistance, even if you apply. Once you send in your application, we will check all the information and may ask for additional information or proof of income.

1. PATIENT INFORMATION

First Name:	Last Name:	Phone:
Date of Birth:	SSN (optional*):	
Address:		
City:	State:	Zip:

I permit Reedsburg Area Medical Center to speak with the following person and/or organization about the information on this application and the status of my application request. These people can provide or receive your personal information as necessary until you terminate their authority. Their authority will not automatically terminate once we process your application. Their authority will terminate at the end of your enrollment period.

Patient Representative/Organization	Relationship to Patient	Phone

2. PRESCRIPTION INSURANCE INFORMATION

Do you have **any** form of prescription drug insurance? □Yes □No *If yes, please provide the information below:*

Plan Name: Member ID: Phone number:

□ Employer-supplied or commercial/private drug insurance
□ VA or Military Benefits
□ Medicaid Prescription Drug Coverage
□ Medicare Part B
□ Low Income Subsidy (LIS/Extra Help)
□ Medicare Part D (prescription drug coverage)

Please include a copy of the front and back of your prescription insurance cards

Medicare Beneficiary Number (MBI) number found on your Medicare Card:

3. FAMILY INFORMATION

List Family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE:_____ *attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years or older: Employer(s) name or source of income	If 18 years or older: Total gross monthly income (before taxes)	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other *(please explain*_____*)*

4. INCOME INFORMATION

You must provide information on your family's income. Income verification is required to determine financial assistance. All members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income. The more documentation you provide, the more accurately we can calculate your eligibility.

Examples includes:

- A "W-2" withholding statement; or
- Current pay stubs (3 most recent); or
- Last year's income tax return; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation

If you have no proof of income or no income, please attach and additional page with an explanation

4. HEALTHCARE PROVIDER INFORMATION

Provider Name and Title:		
Phone:		Fax:
Address:		
City:	State:	ZIP:

5. PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

I give permission to my health care practitioners, my health plan, and insurers to give health and other information about my use or need for medications provided under the Medication Assistance Program to Reedsburg Area Medical Center in charge of administering the Patient Assistance Program. I understand that:

- That people with the Medication Assistance Program, Reedsburg Area Medical Center (RAMC), or others working on behalf of RAMC may see and use my information for administering the Medication Assistance Program.
- That RAMC or the Medication Assistance Program may give my Information to the Centers for Medicare & Medicaid Services (CMS) to confirm my Medicare Part D enrollment status.
- That my information will include my name, address, income, SSN, prescription coverage, prescription for medication(s), financial documents and insurance records.
- That my information will be used to see if I meet the requirements to participate in the Medication Assistance Program
- That the Medicaiton Assistance Program, RAMC, and others helping them will keep my Information private, but that the federal privacy laws may no longer protect my Information once it is disclosed. The Medication Assistance Program will only use my information as described in this form.
- That this authorization will expire 1 year from the date this form is signed.
- That I may cancel this authorization at any time by calling 1-608-524-6868 or 1-608-524-6177
- That if I do not sign this form, I will not be able to participate in the Medication Assistance Program.

By signing below, I acknowledge I have read and agree to the Patient Authorization to Share Health Information above.

Signature of Applicant or Parent/Legally Authorized Representative.
Relation to Patient: □Patient □Parent □Legally Authorized Representative of Patient
Patient Name:_____

X _____ **Date:**_____/_____/_____ (MM/DD/YYYY)

6. PATIENT CERTIFICATION

I understand that:

- Reedsburg Area Medical Center will only use my information to decide if I qualify for the Medication Assistance Program.
- Reedsburg Area Medical Center may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for the Medication Assistance Program.
- My application might not be approved.
- RAMC Pharmacies may change or end the Medication Assistance Program, or terminate my enrollment in the Medication Assistance Program, at any time.
- RAMC Pharmacies does not charge a fee to apply for participation in the Medication Assistance Program.
- I need to be an existing patient of Reedsburg Area Medical Center.
- My prescriptions must be written by a provider employed by Reedsburg Area Medical Center.
- If approved, my enrollment in the Program will expire at the end of the calendar year (if I am a Medicare Part D patient) or after 12 months. After my enrollment expires, I will need to reapply to the Medication Assistance Program.
- I can withdraw from the Medication Assistance Program at any time by calling 1-608-524-6177 or 1-608-524-6868

I agree that:

- My application is complete and accurate. I have been truthful about my insurance coverage and income.
- RAMC Pharmacies can contact me by phone or texting about the Medication Assistance Program or other services that might interest me for which I may be eligible.
- I will promptly provide documentation supporting the information I have provided in this application (e.g., income verification documents) if such documentation is requested by RAMC. (Failure to promptly provide complete and accurate documentation when requested may result in immediate termination of application review or removal from the Program if application has already been approved).
- If my application is approved:
  - I will notify Reedsburg Area medical Center of changes to my income or insurance status.
  - I will not submit any claim for reimbursement to any third party or government insurer for any product provided to me through the Medication Assistance Program
  - If I have Medicare Part D coverage, I will not seek to have the cost/value associated with the medication I receive through the Program counted as out-of-pocket costs for prescription drugs.
  - I will not sell, trade, or transfer any medications I receive through the Medication Assistance Program.

By signing below, I acknowledge I have read and agree to the Patient Certification Information above.

Relation to Patient: □Patient □Parent □Legally Authorized Representative of Patient

Patient Name:_____

X _____ **Date:**_____/_____/_____ (MM/DD/YYYY)