

WV Health Right Patient Eligibility Form 2015

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 _____

EMERGENCY CONTACT PHONE # _____

LANGUAGE : ENGLISH SPANISH FRENCH OTHER _____

Preferred method of contact: Phone email Mail Ok to leave message

BIRTH DATE: _____

SOC. SEC. #: _____

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

Marital Status
 Married
 Single
 Widowed
 Divorced

Race
 White Black Asian
 Am. Indian/Alaskan
 Hawaiian/Pacific Islander
 Two or more Race

Hispanic?
 Yes
 No

Sex
 Female
 Male

Homeless Status
 Shelter Street
 Living with a friend or relative

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

DRUG ALLERGIES? YES NO
If YES, LIST: _____

Do you have a regular doctor? If yes, who? YES NO
 Physician's Name: _____

Last Grade of School Completed:

Medical Insurance Status
 _____ Have you APPLIED for Medicaid Veterans (V.A.)
 _____ Medicaid (white card from the State of WV)
 _____ Private Ins: _____
 _____ Medicare (red/white/blue card)
 _____ No Insurance

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

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

List the full name & age of ALL household members and their income.	Age	Wages/ Pay period	Social Sec. Disability	Retirement	Workers Comp/	Veterans/& Other	TOTAL MONTHLY
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 & medical information, soft credit check and other 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 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.

 Signature date

WVHR Staff to complete this section

Form Completed _____ Date _____ Initials _____

HIPAA Form _____ Date _____ Initials _____

POI Told _____ Date _____ Initials _____

IRS Form _____ Date _____ Initials _____

POI rec'd 2015 _____ Date _____ Initials _____

Photo ID _____ Date _____ Initials _____