

WV Health Right Patient Eligibility Form

NAME _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Last First Middle Initial Maiden Name </small>	BIRTH DATE: _____ SOC. SEC. #: _____			
ADDRESS _____ <small style="text-align: center;">Street Address or PO Box</small>	Are you employed? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Where? _____			
<small style="display: flex; justify-content: space-between; width: 100%;"> City County State Zip Code </small>				
PHONE _____ <small style="display: flex; justify-content: space-between; width: 100%;"> Include Area Codes Home Work Cell </small>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced </td> <td style="width: 50%; vertical-align: top;"> Race Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Am. Indian/Alaskan <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> </td> </tr> </table>	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Race Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Am. Indian/Alaskan <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/>	
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EMAIL ADDRESS _____ EMERGENCY CONTACT PHONE # _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> Hispanic? Yes <input type="checkbox"/> No <input type="checkbox"/> </td> <td style="width: 33%; vertical-align: top;"> Sex Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> </td> <td style="width: 33%; vertical-align: top;"> Homeless Status Shelter <input type="checkbox"/> Street <input type="checkbox"/> Living with a friend or relative <input type="checkbox"/> </td> </tr> </table>	Hispanic? Yes <input type="checkbox"/> No <input type="checkbox"/>	Sex Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/>	Homeless Status Shelter <input type="checkbox"/> Street <input type="checkbox"/> Living with a friend or relative <input type="checkbox"/>
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LANGUAGE : <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> FRENCH <input type="checkbox"/> OTHER _____ Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> email <input type="checkbox"/> Mail <input type="checkbox"/> Ok to leave message				

Have you been to an ER in past year? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, # of times to the ER: _____ If YES, Name of Hospital ER: _____	DRUG ALLERGIES? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, LIST: _____
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Do you have a regular doctor? If yes, who? YES <input type="checkbox"/> NO <input type="checkbox"/> 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
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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) \$ _____
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List the full name & age of ALL house members and their income.	Age	Wages/ Pay period	Social Sec. Disability	Retirement	Workers Comp/	Veterans/& Other	TOTAL MONTHLY
Your Information ➔		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$
Total Household income		\$	\$	\$	\$	\$	\$

<p><u>PATIENT AGREEMENT / DISCLOSURE</u> : 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.</p>	<p><u>WVHR Staff to complete this section</u></p> 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 _____
_____ Signature date	