WV Health Right Patient Eligibility Form

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 house 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 _____

Form Updated 12/2013