Wyoming Medication

Donation Program

*Don't let unused medicine go to waste!*

# Wyoming Medication Donation Program

Wyoming Department of Health,
Pharmacy Services
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**Agency Use:**
Referred by: _____

- ☐ Wyoming Resident
- ☐ Qualifies below 200% of the FPL
- ☐ No RX Insurance
- ☐ Educated about PAP
  - ☐ Already enrolled; waiting on status

Start date: ___/____/____ End date: ____/____/____

Authorized Representative: _____
PRINT FULL NAME

**Patient Information:** **Application Date:**

| Last Name: | First Name: | Middle Name: | Birth Date: | Age: | Gender M / F |
|---|---|---|---|---|---|
| Other Names Used | | | | | |
| Mailing Address: | | | City: | State: | Zip Code: |

***!!!*** *You must provide **proof of residency** with this application (e.g. utility bill, rent receipt, etc.)* ***!!!***

| Home Phone Number: ( ) - | Cell Phone Number: ( ) - | Social Security Number: - - |
|---|---|---|

Race (check one): ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ 2 or More ☐ Other

Primary Language (check one): ☐ English ☐ Spanish ☐ Other:

**Insurance Coverage:** Are you covered by any of the following forms of insurance?

| | | | |
|---|---|---|---|
| Private insurance | Yes / No | ID#: | Company: |
| Medicare Part A / B | Yes / No | ID#: | |
| Medicare Part D | Yes / No | ID#: | Company: |
| Equality Care Card (Medicaid) | Yes / No | ID#: | |
| Kid Care / CHIP | Yes / No | ID#: | |
| Prescription coverage | Yes / No | ID#: | Company: |
| VA Benefits | Yes/ No | ID#: | |
| PDAP (3 scripts per month) | Yes / No | ID#: | |

If yes to any of the above, please explain why you are requesting help from the WMDP:

Are You a U.S. Citizen? Yes / No

Are you a Veteran? Yes / No

Employment (check one):

- ☐ Full time
- ☐ Part time
- ☐ Unemployed
- ☐ Student
- ☐ Retired

Who referred you to the WMDP (How did you hear about the program)?

**Employment:**

| | | |
|---|---|---|
| Employer Name: | | |
| Employer Address: | | |
| City: | State: | Zip Code: |
| Date Hired: | | |

**Household Income:**
List ***all household members*** by name, gender, birthday, age, race, relationship, and insurance coverage:

| Name: | Gender: | DOB: | Age: | Race: | Relationship to Applicant: | Insurance Coverage: |
|---|---|---|---|---|---|---|
| 1. | M / F | | | | | Yes / No |
| 2. | M / F | | | | | Yes / No |
| 3. | M / F | | | | | Yes / No |
| 4. | M / F | | | | | Yes / No |
| 5. | M / F | | | | | Yes / No |
| 6. | M / F | | | | | Yes / No |

**List *ALL sources of household income:***

| Employer or Source of Income: (Example: Employer, Social Security, Retirement, Unemployment, Child Support, etc.) | Amount: | Pay Frequency: (Example: Weekly, Bi-Monthly, Monthly) | Paid To: |
|---|---|---|---|
| 1. | $ | | |
| 2. | $ | | |
| 3. | $ | | |
| 4. | $ | | |
| How many people are supported by this income? Adults _____ Children _____ | | | |

**!!! *You must include PROOF OF INCOME FOR ENTIRE HOUSEHOLD with this application* !!!**
(Such as Pay Stubs for last 30 days, Income Tax return, Social Security Income, Child Support, etc.)

| **Prescription Information:** | | |
|---|---|---|
| Primary Dr. Name: | | Phone #: ( ) - |
| Clinic Address: | | FAX #: ( ) - |
| City: | State: | Zip Code: |
| Medication Allergies: | | |

| Medication Name and Strength (list *all* meds you take): | Directions for use: | Reason for use: | Assistance/ Source? (Please tell us how you currently access this medication. E.g. Cash (not a copay), insurance copay, PAP, samples, other) |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

***A valid prescription is required*** to receive medication from the Wyoming Medication Donation Program. **Choose One:**

☐ Original Rx included with the application (faxed copy from a patient is not acceptable)

☐ Please transfer the refill from my local pharmacy- If yes, include Name of Pharmacy: _____

Pharmacy Phone Number: (____)_____-_____ Rx Numbers to transfer (separate each with a comma):

_____

☐ Please contact my prescriber for the prescription- Prescriber Name:_____

Phone Number: (____)_____

Name of medications requested:

- *My signature indicates that all of the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance.*
- *I acknowledge that the medication I receive through this program was originally dispensed to another patient and has been donated to the Wyoming Medication Donation Program for re-dispensing.*
- *In accordance with the Drug Donation Program Act and the Administrative Procedures Act W.S. § 16-3-10; I understand that any person or entity which exercises reasonable care in donating, accepting, distributing, dispensing medications under the Drug Donation Program Act or rules and regulations adopted and promulgated under this act shall be immune from civil or criminal liability or professional disciplinary action of any kind for any related injury, death, or loss.*

Signature of Applicant: _____ Date: _____