Medication Assistance Program (MAP)

4920 S. 30th St Ste 105 Omaha, NE 68107
Phone: (402) 502-5832-Fax: (402) 502-5841-Email: Pharmacy@hopepharmacy.us

What the program does:

- ★ **We apply to pharmaceutical manufacturer's programs in conjunction with your health care provider. Many manufacturers offer special programs for low-income people who do not have prescription drug coverage to obtain medication they would not otherwise be able to afford.**
- ★ **Please note, not all medications are available throught the MAP program, such as medications with generics or narcotics.**
- ★ **Most programs will supply up to 3 months of medication at a time. We will automatically reorder your medication if it is an ongoing medication. We charge an administrative fee for each supply of medication dispensed to cover program operation costs.**

To participate in Hope's MAP program:

- ★ **You need to see a medical provider at one of Hope's Network Clinics.**
- ★ **Provide a prescription from your medical provider for a MAP medication.**
- ★ **Not have prescription drug coverage (i.e. Health Insurance, Medicaid, VA drug benefits, or any other program that pays for prescriptions).**
- ★ **In general, have a household income that is 200% or less than Federal Poverty Level**
- ★ **Provide proof of income for your household**
- ★ **Meet other criteria that is specified by a particular pharmaceutical manufacturer (varies)**
- ★ **Renew your enrollment form annually**

TO ENROLL IN OUR MAP PROGRAM YOU NEED TO DO THE FOLLOWING:

- ★ **Completely fill out the entire MAP enrollment form, sign, and date. Incomplete forms may delays the processing of your medication.**
- ★ **Provide Proof of Income for your household.**
  - ☐ **One month of recent pay stubs.** / /
  - ☐ **Letter from employer with gross monthly earnings**
  - ☐ **Copy of the latest Unemployment Statement**
  - ☐ **Copy of last Social Security Disability**
  - ☐ **Copy of current Social Security Retirement Statement of benefits**
  - ☐ **Copy of Pension statement**
  - ☐ **Copy of recent tax return (W-2 and 1040)**
  - ☐ **Other** ________________

You may bring your prescription, application and proof of income to Hope Pharmacy or mail it to us to the following address:

Attention: Pharmacy MAP coordinator
Hope Medical Outreach Coalition
4920 S 30th St Ste 105
Omaha, NE 68107

If you have any questions call us at:
(402) 502-5832

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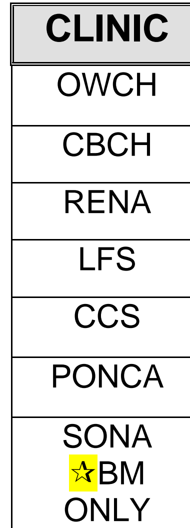
NEW APPLICATION ❒
RENEWAL ❒

Medication Assistance Program (MAP)
Enrollment Form

PLEASE WRITE CLEARLY:

SECTION 1- PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI	
MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE NUMBER: ( ) ________-___________	CELL PHONE NUMBER: ( ) ________-___________		
E-MAIL____________________________________	Would you like us to send you corespondence thru E-Mail? YES ❒ NO ❒		



CLINIC
OWCH
CBCH
RENA
LFS
CCS
PONCA
SONA ☆BM ONLY

Sex	Race	Date of birth	Social Security Number	Marital Status
Male ❒ Female ❒	Hispanic ❒ Caucasian ❒ AfricanAmerican ❒ Other ______ ❒	____/___/_____ Month day Year	______-_____-______	Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other_________ ❒

★**Do you have any drug allergies? YES ❒ NO ❒ If yes please list__________________**

SECTION 2 – INSURANCE INFORMATION

★**Do you have medical or drug benefits through any of the following programs?**
(Y = Yes, N = No, P = Pending)

PROGRAM	Medical Benefits	RX Benefits
Medicare	Y N P	Y N P
Medicaid	Y N P	Y N P
Private Insurance	Y N P	Y N P
VA Assistance	Y N P	Y N P
Other_________________	Y N P	Y N P

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SECTION 3 –HOUSEHOLD INCOME

☑PLEASE CHECK YES OR NO AND WRITE IN THE HOUSEHOLD **GROSS MONTHLY INCOME**.
IF YOU DO NOT WORK THEN WRITE IN THE NAME OF THE PERSON SUPPORTING YOU.

Employment	Unemployment Benefits	Social Security Disability	Social Security Retirement	Pension	Other
YES ❒ NO ❒ $__________ Who receives this income?	YES ❒ NO ❒ $____________ Who receives this income?	YES ❒ NO ❒ $__________ Who receives this income?	YES ❒ NO ❒ $__________ Who receives this income?	YES ❒ NO ❒ $_________ Who receives this income?	YES ❒ NO ❒ $__________ Please explain what kind and who receives it

★**How many people depend on the household income including yourself?**

ADULTS: ___________________	**CHILDREN** ***(Under the age of 18):*** ________________

SECTION 4—PATIENT CONSENT AND RELEASE

I certify that the information I have provided in this application is accurate and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that other documents may be required to provide proof of income. By signing this application, I authorize representative of Hope Medical Outreach Coalition (Hope) to ask necessary information of my health care providers to complete applications for medication assistance, and to share this information with pharmaceutical companies as required. I also give permission to the representatives of Hope to sign applications for me in the event of my absence. I will notify Hope if I become eligible for Medicaid, Medicare, Health Insurance, Worker's Compensation, or VA Health benefits,

Signature of Applicant: X_________________________________ **Date:X**_____________

For Staff Personal Only

Total Annual Household Income	Number of persons in household	% Calc	Scale Letter	Approved YES NO	Enrollment Period
					____/____/____TO____/____/___