SIERRA VISTA COMMUNITY HEALTH CLINIC
SIERRA VISTA COUNSELING CENTER
800 East Ninth Avenue
Truth or Consequences, New Mexico 87901
Phone 575-743-1390 Fax 575 894-4999

Thank you for your interest in our **MEDBANK** Program. The **MEDBANK** Program has been made available to both the Sierra Vista Rural Health Clinic and Sierra Vista Behavioral Health Clinic through the New Mexico Aging and Long Term Services Department. This program helps people of all ages to receive their prescription medications free from the pharmaceutical companies' Patient Assistance Programs.

The **MEDBANK** Program will enable us to provide more efficient service to those requiring medication assistance. Only brand name medications are available through the **MEDBANK** Program. Our Patient Assistance Program will make every effort to seek out programs to assist our patients.

BE SURE TO…fill out the patient forms and gather copies of the required attachments.

When you have completed all your forms, keep the instruction and information pages and return the completed forms, along with other required information, such as Proof of Income, prescriptions (if presented to you by your provider), to the Patient Assistance Office.

If you have any questions OR need assistance in filling out these forms, please stop by the Patient Assistance Office or call 743-1396.

If you are already receiving medication assistance, please fill out these forms and return with your most recent Social Security Award letter OR with current proof of income as indicated in the packet instructions. We will be entering this information into the computer program in your behalf, therefore **YOU WILL NO LONGER HAVE TO FILL OUT THE FORMS.**

All data collected by the Sierra Vista Patient Assistance Office is treated as private and confidential. The patient must agree to share their private information with the pharmaceutical companies to obtain their free medications.

PROOF OF INCOME

You will need to provide proof of income for ALL applicable household members, including yourself.

Without complete proof of income, we cannot process your application.

This is what you will need to **bring in** along with your completed application:

1- ~Photo ID

2 - ~If you are working we require **current paycheck stubs** or a letter from the company/person you work for that reflects **3 month's income**
~Copy of your most recent **federal income tax forms**

3 - If you did not file federal income tax in the most recent year, we will provide you with Form 4506-T indicating you did not file federal income tax

4 - ~You are **required** to supply written proof of denial of assistance services from New Mexico Income Support Division **(Medicaid Letter of Denial)**.

5 - ~If claim no income & living expenses are provided in trade for rent/food, must bring **Notarized** letter from person stating amount as part of Proof of Income

If you or any other applicable household member receives any other source of income, we will need that information also. These are some examples of other sources of income that you need to include:

-Social Security, VA Benefits
-Pensions, Retirement
-Public Assistance
-Unemployment
-Disability Income
-Worker's Compensation
-Child Support, Alimony

We will need **proof of any assets you may own.** These are examples of assets:

-Bank accounts-savings/checking
-Stocks, Mutual Funds, Bonds
-Land or House that you do NOT live in
-Certificates of Deposit
-Trust Funds

SIERRA VISTA RURAL HEALTH CLINIC
Medication Assistance Program

PATIENT QUESTIONNAIRE

PROOF OF INCOME MUST ACCOMPANY COMPLETED APPLICATION

PRINT OR TYPE ONLY **DATE: ___________**

Last Name___________________________First_________________________Initial________

Date of Birth: _____________ SS# ____

Address____

City_______________________________________State_____________Zip _______________

County_________________________________Phone_____________________________________

Primary Language: ☐ English ☐ Spanish ☐ Navajo ☐ Other _____________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Other _____________

How many people live in your household? ____ Dependents on your tax return? _________

Does anyone claim you on his/her tax return? ___________

Who is your primary care provider/family doctor? ________________________________

What is the name of his/her private/practice/clinic/hospital __________________________

What is his/her phone number? ____

How did you hear about MEDBANK? ____

Are you a US Citizen or legal resident? ☐ Yes ☐ No

DID YOU FILE A TAX RETURN THIS YEAR? ☐ Yes ☐ No

If No, you will be asked to complete IRS Form 4506-T when you bring your completed application to our office.

PATIENT QUESTIONNAIRE

Do you have income from any of the following sources? If yes, please indicate how much you receive each month. If you received income from a source not listed below, please

specify the source under “Other” Income includes household income, for example…a spouse’s income.

Supplemental Social Security ☐ No ☐ Yes Monthly Amount $ ________________

Disability ☐ No ☐ Yes Monthly Amount $ ________________

Pension ☐ No ☐ Yes Monthly Amount $ ________________

Unemployment ☐ No ☐ Yes Monthly Amount $ ________________

Social Security ☐ No ☐ Yes Monthly Amount $ _______________

Alimony/Child Support ☐ No ☐ Yes Monthly Amount $ _______________

Salary/Wages ☐ No ☐ Yes Monthly Amount $ _______________

Other: _________________ ☐ No ☐ Yes Monthly Amount $ ________________

Please indicate if you have any of the following medical expenses. If you do, please indicate how much you pay each month. If you have other medical expenses, please specify them under “Other.”

Prescription Medications ☐ No ☐ Yes Monthly Amount $_________________

Lab Fees ☐ No ☐ Yes Monthly Amount $ ________________

Office Visits ☐ No ☐ Yes Monthly Amount $ ________________

Other: __________________ ☐ No ☐ Yes Monthly Amount $ ________________

_____________________ ☐ No ☐ Yes Monthly Amount $ ________________

Do you have any of the following assets? If yes, please indicate their current value. If you have any assets not listed below, please specify them under “Other.”

Stocks and/or Bonds ☐ No ☐ Yes Current Value $ ________________

Certificates of Deposit (CD) ☐ No ☐ Yes Current Value $ ________________

Checking Account ☐ No ☐ Yes Current Value $ ________________

Savings Account ☐ No ☐ Yes Current Value $ ________________

Individual Retirement/IRS ☐ No ☐ Yes Current Value $ ________________

Annuities ☐ No ☐ Yes Current Value $ __________________

PATIENT QUESTIONNAIRE

Please complete the following information about your health insurance:

Primary Insurance Policy: ___________________________ Policy Number: _______________

Secondary Insurance Policy: ________________________ Policy Number: _______________

Do you have insurance that covers Prescriptions? ☐ Yes ☐ No

If yes, how much is covered per year? $_____________________

Have you reached this limit? ☐ Yes ☐ No If yes, when? ________________

When will you have coverage again? ______________________________________

Do you have Medicare coverage? ☐ Yes ☐ No Medicare # _________________

Do you have Medicaid Coverage? ☐ Yes ☐ No

Do you have Veterans Assistance? ☐ Yes ☐ No

Do you use any pharmaceutical company discount cards? ☐ Yes ☐ No

If yes, which one(s)____

0PTIONAL: When was your last…..

Office Visit Date: ________________ Reason: ______________________

Stay in hospital Date: ________________ Reason: ______________________

Emergency room Date: ________________ Reason: ______________________

OPTIONAL: Please complete the following information if there is an *alternative* contact family member, social worker, etc.) that we should communicate with.

Last Name: __________________________________ First: ___________________

Street Address: ________________________________Suite/Apt #: _____________

City _______________________State ____________________ Zip _____________

Phone Number _____________________Relationship to patient: ____________________

Should this be our primary contact? ☐ Yes ☐ No

If yes, please indicate why____

PERSONAL INFORMATION RECEIVED WILL BE TREATED WITH CONFIDENTIALITY AND VIEWED ONLY BY MEDBANK PERSONNEL. THE PATIENT MAY INSPECT INFORMATION WE HAVE ON FILE AT ANY TIME AND REQUEST THAT CHANGES BE MADE.

PATIENT/PRESCRIBER REFERRAL FOR MEDICATIONS – NEW MEDBANK PATIENT ONLY

PATIENT CONSENT & RELEASE FORM
EXCHANGE OF INFORMATION

I give permission to authorized representatives of The New Mexico MEDBANK Program to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications

through patient assistance programs. I also authorize MEDBANK to discuss my medical needs with my physician/prescriber when necessary. Additionally, I give MEDBANK permission to verify my income through the Dept. of Social Services, Social Security Administration, my employer, Veterans Administration or any other company, business, or organization from which I receive income. This authorization is valid for a period of one year from the date this document is signed, and for as long as MEDBANK is assisting me OR until I revoke this agreement.

I agree that a copy of this form can be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company or organization individually to give them information about me that they need.

Date of Birth: SS#___________________________

Address:____

Full Printed Name of Patient:____

Signature of Patient:____

Date:____

PATIENT SIGNATURE AUTHORIZATION

I AUTHORIZE REPRESENTATIVES OF THE NEW MEXICO MEDBANK PROGRAM TO SIGN FORMS ON MY BEHALF FOR THE PURPOSE OF REQUESTING MEDICATIONS ON MY BEHALF FROM COMPANIES THAT MANUFACTURE OR PROVIDE MEDICATIONS THROUGH PATIENT ASSISTANCE PROGRAMS. THIS SIGNATURE AUTHORIZATION IS GOOD AS LONG AS MEDBANK IS ASSISTING ME OR UNTIL I REVOKE SUCH.

Full Printed Name of Patient:____

Signature____ Date: _______________________

PATIENT QUESTIONNAIRE

MEDBANK PROGRAM - PATIENT MEDICATION LIST

PATIENT NAME: LAST **FIRST**

SS#____

PHYSICIAN'S NAME____

BRAND NAME MEDICATION	DOSAGE	FREQUENCY	DIAGNOSIS

AS FAR AS YOU KNOW, ARE YOU ALLERGIC TO ANY MEDICATIONS?

☐ **yes** ☐ **no** **If yes, please list:**____________________________________