**MAIL OR FAX THIS FORM**
Phone: 805-614-2040
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Main Office: 506 E. Plaza Dr. Suite #5
Santa Maria, CA 93454
www.apameds.org

IMPROVING ACCESS TO LIFE-SAVING MEDICATIONS ONE PATIENT AT A TIME

# Alliance for Pharmaceutical Access Patient Intake Form

First Name _____ (Middle Int.)_____Last Name_____

Address _____City: _____State:_____ Zip: _____

Home Phone (_____) _____ Cell (_____) _____

Date of Birth _____/_____ /_____Age_____ Social Security #_____

*Emergency contact*: Name: _____ Phone _____
*Relationship*: _____
Does this person have permission to access information about your case? □ Yes □ No

*How did you hear about us or who were you referred by*? _____

May we contact you via E-mail? □Yes □No E-mail address: _____

Gender: F□ M□ Marital Status: Single □ Married □ Divorced □ Separated □ Widowed □

Ethnicity**:** White □ Latino/a □ Hispanic □ Asian □ Native American □
African American □ Other □ _____

What is your total household income? If you are married include your spouse's income (wages, social security, disability, unemployment, cash aid, pension, child support, etc.) $_____per month
How many dependents do you have in your household (children under the age of 18) #_____

**Do you have health insurance?** □Yes □No *If yes, please provide a copy of your insurance card (s)*
What type of health insurance coverage do you have? _____
Does it cover medications? □ Yes □ No
How much do you spend on medications each month (your share of cost)? $_____per month
**If you have Medicare? Please check all that apply:** A □ B □ C □ **/** Part D □ ***If you have Part D, how much have you spent on medications this year? (From January to now):_____

**List all of your current medications or include a copy of your prescriptions. If you need additional space please use the back of this form.**

Drug name: _____ Dosage: _____ Prescribed by: _____

Drug name: _____ Dosage: _____ Prescribed by: _____

Drug name: _____ Dosage: _____ Prescribed by: _____

Drug name: _____ Dosage: _____ Prescribed by: _____

List your health diagnosis: _____

Allergies ☐ No ☐Yes If yes, Please list:

_____

_____

## *Patient Acknowledgement*
READ BEFORE SIGNING

*Alliance for Pharmaceutical Access (APA) is a non-profit organization that provides free medication advocacy services to chronically ill community members. In consideration for accepting services performed by APA, I acknowledge:*

1. I permit Alliance for Pharmaceutical Access (APA) to render services on my behalf for the acquisition for prescribed medications.
2. I understand that APA will only facilitate the application process. I understand that APA is neither a pharmacy/pharmacist nor physician. I further understand that I must take my medications directed by my physician. I will consult my physician or pharmacist with any questions I may have regarding my medical condition, medications, or prescription drugs.
3. I also understand there are potential risks of which I may not presently be aware.

### LIABILITY WAIVER

I Waive, release and discharge Alliance for Pharmaceutical Access (APA) and its officers and employees from any and all negligence and liability for my death, disability and personal injury, property damages, property theft or claims of any nature which may hereafter accrue to me, and my estate as a direct or indirect result of services rendered by APA. I hold harmless APA and its agencies, officers, and employees of, from and against any and all claims of any nature including cost, expenses, and fees arising out of resulting from services rendered by APA.

I, affirm that I am at least 18 years of age and am freely signing this agreement. I have read this form and fully understand that by signing this form I am giving up legal rights and/or remedies which may otherwise be available to me regarding losses I may sustain as a result of services rendered to me. I have had the opportunity to review this from both here and outside of the presence of the Alliance for Pharmaceutical Access and choose to sign of my own free will. I agree that if any portion is held invalid, the remainder will continue in full legal force and effect.

_____ _____

**Patient's Signature** **Date**

### HIPAA AUTHORIZATION

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person/s or facility staff is authorized to use or disclose information about me:

**Alliance for Pharmaceutical Access, Inc. (APA)**
Program Director and Health Advocates in San Luis Obispo and Santa Barbara Counties.

The specific information that should be disclosed is:

This authorization will give Alliance for Pharmaceutical Access, Inc. (APA) Health Advocates the ability to communicate on your behalf with any pharmaceutical company; business, organization, and/or individual in order to verify enrollment status for the Patient Assistance Programs and/or checking on your medication re-order status. By signing this form, you are giving authorization to APA to use your personal information in facilitating and completing your patient assistance application/s.

_____ _____

**Patient's Name** **Date of Birth**

_____ _____

**Patient's Signature** **Date**

Authorized Representative's Name (print name) _____

Relationship: Patient Advocate Phone Number: 805-614-2040 EIN: 20-3117940

Authorized Representative's Signature: _____Date: _____