St. Vincent de Paul Pharmacy

5750 Pineland Drive, Suite 280
Dallas, TX 75231
(469) 232-9902

Hours: Monday – Friday
9am – 2pm

Service at St. Vincent de Paul Pharmacy (SVdP)

St. Vincent de Paul Pharmacy provides prescription medication at no cost to residents of North Texas who do not have health insurance and who cannot afford to purchase them at a retail pharmacy. If you need medication and you (1) reside in the state of Texas, (2) do not have health insurance coverage of any kind, and (3) have a certain level of income**, we are here to help.

Applying for Service

Each patient of SVdP Pharmacy must apply for service and show that you meet the above criteria.

PLEASE read each page of the intake form carefully and complete each form as completely as possible. If you have questions, call the pharmacy, or come by and we can help you!

Below are a list of documents you must provide to apply, along with special notes about the application form.

1. Valid Prescription

If you have a paper copy of a prescription from a doctor, bring it with you to the pharmacy. If your prescription(s) are on file with another pharmacy, you must bring the name, address and phone number of your pharmacy with you, and we will have your prescription transferred electronically.

2. Proof of Residence

To prove your residence in the state of Texas, you may bring a government issued photo ID **or one (1) of the following**:

- A lease or mortgage agreement, utility bill or other piece of recent mail showing your name and current address,
- Treatment program identification, as verified by your case manager (or a letter from your case manager),
- If you cannot verify your place of residence, complete the **Homeless Shelter Referral Letter** on page 7.

3. Income Verification**

Staff at the pharmacy will help you determine whether your total annual income qualifies you for service. The type of income you receive determines which types of documentation you must submit with your application.

If you have employment income from a place of work, bring:

- Last year's tax return, and two (2) most recent pay checks or paystubs.
- If you cannot provide recent pay stubs, bring a letter from your employer, detailing the number of hours you work each pay period and the amount you make per hour.

If you do not work, but receive income from other sources, bring:

- Letters or statements which show that you receive payments from sources such as Social Security, Child Support, Food stamps, retirement or disability.
- The **Monthly Income and Expense Detail** form on page 4 shows all the types of income recognized by SVdP Pharmacy, which must be documented in your application.

If you have no income from a job or any other source, please complete:

- **Acknowledgement of Support for Monthly Expenses** form on page 5 to show how you cover living expenses.

If you have no income or you are unsure how to verify your income, please call the pharmacy at (469) 232-9902.

COVID-19 Application Process: (Updated November 2020)

If you print and fill these forms out by hand, please scan and email it to rchavez@svdpdallas.org or gloredo@svdpdallas.org. If you fill out the forms on the computer, MAKE SURE to save them to your computer, titled with your name; then submit by emailing, or fax it to **469-687-9126**.

St. Vincent de Paul Pharmacy

Date _____

Patient Information

Every patient must complete this form.

Last Name Type text here _____ **First Name** _____ **Initial** _____

Address _____

Phone _____ **Social Security #** _____ **Gender** ☐ Male ☐ Female

Date of Birth (mm/dd/yyyy) _____ **Age Range:** ☐ 0-17 ☐ 18-29 ☐ 30-49 ☐ 50-64 ☐ 65+

Race/Ethnicity ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ White ☐ Other _____

Primary Language _____ **Interpreter Needed?** ☐ Yes ☐ No

Education Completed ☐ None ☐ Elementary School ☐ High School/GED ☐ 2 Years College ☐ 4 Years College

Employment ☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other _____

Are you a Veteran? ☐ Yes ☐ No **Do you have a Case Manager?** ☐ Yes ☐ No

If you have a case manager or someone referred you, please list the name of the individual and/or organization:

_____

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

Spouse Information (if applicable)

Last Name _____ **First Name** _____ **Initial** _____

Date of Birth (mm/dd/yyyy) _____ **Social Security #** _____ **Gender** ☐ Male ☐ Female

Employment ☐ Full-Time ☐ Part-Time ☐ Temp ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student ☐ Other _____

Is your spouse a veteran? ☐ Yes ☐ No

Other Household Member Information

Total # in Household (including patient): _____

Please use back of page to detail additional family members.

Name	Gender (M/F)	Age	Relationship

St. Vincent de Paul Pharmacy

Date _____

Medical and Prescription Information

Health Insurance ☐ Medicare ☐ Medicaid ☐ VA Benefits ☐ Other _____ ☐ None

Please list Medication(s) Needed: _____

_____

_____

Please list any Allergies to medications and your reaction:_____

_____

In the last 12 months, have you been admitted to the hospital or visited an emergency room for your condition?

☐ Yes ☐ No If yes, how many times? _____

How did you hear about SVdP Pharmacy? ☐ Radio ☐ TV/News ☐ Internet/Website ☐ Church [Give Name, if possible]: _____ ☐ Other _____

Consent to Treatment by Volunteers

Please read carefully and add your signature below.

I understand that services I receive from St. Vincent de Paul Pharmacy may be provided by a volunteer who is providing care that is not administered for or in expectation of compensation.

I further understand that Texas Law imposes limits on the recovery of damages from such a volunteer in exchange for receiving health care services. Those limitations include immunity from civil liability for any act or omission resulting in death or injury to a patient if:

1) The volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization.
2) The volunteer commits the act or omission in the course of providing health care services to the patient.

I acknowledge that the health care providers, as volunteers, are providing me with care that is not administered for expectation of compensation, and in exchange for receiving the health care services, recovery of damages is limited.

( ) Myself

( ) The following person for whom I am legally responsible: _____

Print Patient's Name _____ **Date** _____

Patient's Signature _____ **Date**_____
(Or Signature of legal guardian)

St. Vincent de Paul Pharmacy

Date _____ 4

Monthly Income and Expense Detail

Every patient must complete this form. Pharmacy staff will help you complete the bottom portion below the line.

Income from Employment

Name of Employer _____ ☐ Unemployed

Wage Amount: _____ **Wage Frequency:** ◯ Hourly ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly

Taxes Paid Last Year_____ **Tax Refund Last Year** _____ ☐ No Taxes Filed Last Year

Income from Other Sources

In order to verify your total annual income, we must account for all types of income received. Apart from wages or a from a place of employment, your "Income" includes any payments received from any of the following sources. If possible, please provide any statements or documentation which show these payments:

- Tips,
- Unemployment benefits,
- Social Security benefits,
- Welfare benefits,
- Disability, worker's compensation, or other payments for an injury or illness,
- Retirement or Pension benefits,
- Alimony or Child Support payments,
- Annuity or Life Insurance payments,
- Interest or Dividends from savings accounts or Investments, or any withdrawals from these accounts,
- Rental Income or income from your business,
- Income from Royalties, Patents, Gambling or Lottery winnings.

Expense Detail

In the table below, please list the costs of your living expenses. You do not have to list the exact amount; just estimate the average within a few dollars.

Expense	Monthly Cost	Expense	Monthly Cost
Rent/Mortgage		Food	
Utilities (Electricity, Water, etc)		Clothing, Hygiene, Basic Needs	

PHARMACY STAFF: Income from Other Sources Detail

Source/Organization	Monthly Amount Paid

Total monthly household income: _____ **Total annual household income:** _____

I have reviewed this income section with the applicant and verified their total annual household income.

Intake Screener Signature _____ **Date** _____

St. Vincent de Paul Pharmacy

Date _____

Acknowledgement of Support for Monthly Expenses

Every Patient must complete this form. Please show how you cover your basic living expenses in the table below. Note whether you, an organization or an individual (friend or relative) pays for the expense. If you cover the expense yourself, simply write "Self" in both columns.

Monthly Expenses

Expense	Payment Source: Self, Individual, or Agency?	Supporter's Name: Agency/Organization Name or Individual's Full Name and Relationship
Rent/Mortgage		
Utilities (Electricity, Water, etc)		
Food		
Clothing, Hygiene, Basic Needs		

Acknowledgement of Support – *To Be Signed by Individuals or Organization Representatives, if Applicable. If you cover all your own expenses, you only need to sign on the Patient Signature line at the bottom.*

By my signature, I attest that this applicant has no income or insufficient income and that I, or the organization I represent, provide(s) financial support for their living expenses.

Name of Support Contact – Rent _____

Signature _____ **Date**_____

Name of Support Contact – Utilities _____

Signature _____ **Date**_____

Name of Support Contact – Food _____

Signature _____ **Date**_____

Name of Support Contact – Basic Needs _____

Signature _____ **Date**_____

Patient Signature _____ **Date** _____
(Or Signature of legal guardian)

St. Vincent de Paul Pharmacy

Date _____

Terms of Service Agreement

Every Patient must complete this form. Please read carefully and add your initials to each section. Your initials mean that you have read, understand and agree to each statement.

_____ **Terms of Qualification for Service**

I acknowledge that the terms concerning qualification for service at St. Vincent de Paul Pharmacy have been explained to me and I understand them. I also understand that I have been certified for up to twelve (12) months, and I understand that re-verification of qualification for service at the Pharmacy is needed to continue receiving medications beyond that date.

_____ **Change of Information Agreement**

I attest to the above information as true to the best of my knowledge, and will report any change of my address, my insurance status or income to SVdP Pharmacy immediately. I understand that any of these changes may affect my qualification for service at the pharmacy.

_____ **Consent and Release**

I understand that any information I provide to SVdP Pharmacy will be kept confidential. However, I hereby authorize SVdP Pharmacy to share my information, including but not limited to my name, address and other personal information with other medical facilities and/or pharmaceutical manufacturers participating in my care in order to coordinate services. I also authorize SVdP Pharmacy to share my information, including eligibility and prescription records, with any Pharmaceutical Manufacturers Patient Assistance Program(s), or their designee, for which I qualify, for auditing purposes. I understand that this consent is authorized for twelve (12) months from the date signed below, and that I may revoke this consent at any time by submitting a request in writing to SVdP Pharmacy, except when action has already been taken to obtain and/or release such information.

_____ **Permission to Release Information for Patient Assistance Program Qualification**

I also authorize St. Vincent de Paul Pharmacy to use my information, including prescription records, to assist me in finding any Patient Assistance Program(s) for which I qualify, in order to assist me in accessing these programs, and to coordinate services.

By my signature, I indicate that I agree overall to the terms and conditions of service at St. Vincent de Paul Pharmacy. If the patient is a child under the age of 18, I sign as their legal guardian.

Patient's Name Print _____ **Date** _____

Patient's Signature _____ **Date** _____
(Or Signature of legal guardian)

COVID-19 Application Process: (Updated November 2020)

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St. Vincent de Paul Pharmacy

Date _____

Homeless Shelter Referral Letter

Please complete this form if you are homeless or otherwise unable to verify your place of residence. This letter must be completed by the individual, organization or advocate who provides housing support for you.

RE: St. Vincent de Paul Pharmacy:

For (Applicant Name): _____

To Whom It May Concern,

This letter is to verify that _____ is homeless, as defined below (please choose one):

☐ An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:

A. *An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport or camping ground; or*

B. *An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations, or by federal, state, or local government programs for low-income individuals); or*

C. *An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.*

☐ An individual or family who are fleeing, or are attempting to flee domestic violence, dating violence, sexual assault, stalking or other dangers or life-threatening conditions that relate to violence against the individual or a family member.

Their current income is _____ ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly,

And their income source is _____. This letter verifies that the individual named above needs shelter/supportive housing. Please let us know if you require additional information regarding this individual or family.

Sincerely,

Individual/Organization Name _____

Title/Relationship _____

Email _____ Phone _____

Date _____