Prescription Assistance Program

Date: _____ CDIB No. _____

Name: _____ If child, Parents Name: _____

Address: _____ _____ _____ _____

(Street Address) *(City)* *(State)* *(Zip Code)*

Date of Birth: _____ Home No. _____ Work No. _____ Cell No. _____

Name of Hospital: _____ Physician's Name: _____

Diabetic: Yes ☐ No ☐

Type of Medical problem/condition: _____

(Please list)

Type of Insurance: Medicare – Medicaid -Title IX - Private Insurance - other _____

(Please list)

The Prescription Assistance Program will provide assistance with medication that the Indian Health Service does not provide and assist with co-pays for those that have medical insurance. No voucher will be issued for cosmetic or male/female enhancement prescriptions.

To be eligible for services, the client must complete an application, provide a copy of CDIB, and submit a written prescription from a physician. It is the responsibility of the client to get all the necessary documents that is needed.

Upon receipt of a prescription for medication, a voucher will be issued for up to and not to exceed $100.00. The difference over this amount will be the responsibility of the client. The Prescription Assistance program can assist clients once a month (30 days from last voucher issued). This program is not intended to replace any existing resources that the client may have access to such as, Medicare, Medicaid, Title IX, private insurance, DHS, VA, or any other resources.

I have read and understand the policy and will abide by such:

_____ _____

Client Signature **Name of Staff**