P.O. Box 281496 • Nashville, TN • 37228
P: 615-736-5075 • F: 615-736-5624
Toll Free: 888-428-HOPE

Dear Enrollee,

You've come to the right place! The Dispensary of Hope is excited for the opportunity to help you get the medications you need through our Continued Access Program for prescription assistance.

Please complete the Patient Enrollment Form and mail back along with your proof of income, photocopy of your ID, prescription(s) and payment. If Patient Enrollment Form is incomplete and/or does not include the required attachments, it will be return to you and will delay your enrollment into the program. To ensure you are enrolled as quickly as possible, please refer to the checklist below.

Enrollment Checklist

- ☐ **Complete and sign the Dispensary of Hope Patient Enrollment Form**
- ☐ **Attach a photocopy of your proof of identification**
  - ***Driver's License, OR***
  - ***Passport, OR***
  - ***State Issued Identification***
- ☐ **Attach a photocopy of proof of income for you and *<u>all members</u>* of household over age 18**
  1. If you filed taxes: ***Tax Return*** *(If missing, call 1-800-829-1040 to get a copy)*
  2. If you did not file taxes: ***Pay Stubs*** *(last month's worth)*
  3. If you did not file taxes and are not working*:* ***4506-T Form*** *(one for each prescription; no copies; download at http://www.irs.gov/pub/irs-pdf/f4506t.pdf) AND* ***Letter of Support*** *from prescriber*

  In ADDITION to 1, 2, or 3 include the following documents should they apply: ***Social Security*** *Notice of Awards letter,* ***Disability*** *Notice of Award letter,* ***Unemployment*** *statement, and/or* ***Pay Stubs*** *(if making less than reported on most recent tax return; last month's worth)*
- ☐ **Attach original prescription(s)**
  - ***Brand-name medications only*** *(see formulary)*
  - ***Written for 90 days with 3 refills***
  - ***Multiple prescriptions must be written on separate prescription forms***
- ☐ **Annual $45 Subscription Fee**
  - ***Cashier's Check, OR***
  - ***Money Order , OR***
  - ***Credit Card*** *(Include credit card information on Enrollment Form)*

Mail to Dispensary of Hope, P.O. Box 281496, Nashville, TN 37228

Enrollment in the Dispensary of Hope Continued Access Program is for one (1) year. If you are approved, you will receive a welcome letter notifying you of your enrollment. If for any reason you are denied, you will receive a denial letter and your Patient Enrollment Form, prescriptions, supporting documents and payment will be returned to you.

If you have any questions or need further assistance, please call 1-888-428-HOPE(4673).

DISPENSARY OF HOPE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

YOU SHOULD ALSO SHARE A COPY OF THIS NOTICE WITH YOUR FAMILY MEMBERS, FRIENDS, ETC. WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE.

This notice affirms that the Dispensary of Hope is dedicated to maintaining the privacy of your health information. In our operations, we create records regarding you and the benefits/services we provide you. This Notice will tell you about the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Maintain the privacy of your health information, also known as PHI
- Provide you with this Notice, and
- Comply with this Notice

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this Notice, we will distribute the new Notice to you within 60 days of the revision. You may obtain a paper copy of the current Notice by contacting the Dispensary of Hope using the contact information we provide at the end of this Notice.

HOW THE DISPENSARY OF HOPE MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your PHI for certain purposes without your permission or authorization. The following gives examples of each of these circumstances.

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for, or stock replenishment of the treatment you receive under the Dispensary of Hope benefit.
3. **For Health Care Operations.** We may use or disclose your PHI for our health care operations. For example, we may verify periodically your eligibility status with the state Medicaid system or other insurance benefits, which may be responsible for the cost-management and planning of your medications.
4. **To the Plan Sponsor.** We may disclose your PHI to the Dispensary of Hope executive and planning personnel only for purposes of maintaining your eligibility for enrollment in the plan.
5. **For Health Related Plans and Services.** The Dispensary of Hope may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Responsible for Your Care.** We may disclose your PHI to a family member or friend who is involved in your medical care provided that you agree to this disclosure, or we give you the opportunity to object to this disclosure. However, if you are unavailable or are unable to agree or object, we will use our best judgment to decide whether this disclosure is in your best interest.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATION

The law allows us to disclose your PHI in the following circumstances without your permission or authorization.

1. **When Required by Law.** We will use and disclose your PHI when we are required to do so by federal, state, or local law.
2. **For Public Health Risks.** We will use and disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products and reporting the abuse or neglect of children, elders and dependent adults.
3. **For Health Oversight Activities.** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits and licensure.
4. **For Lawsuits and Disputes.** We may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request of obtaining an order protecting the information the party has requested.
5. **To Law Enforcement.** We may release PHI if asked to do so by a law enforcement official for the following circumstances:
   - Concerning a death we believe might have resulted from criminal conduct;
   - Regarding criminal conduct at our offices;
   - In response to a warrant, summons, court order, subpoena or similar legal process;
   - To identify/locate a suspect, material witness, fugitive or missing person;
   - In an emergency, to report a crime (including the location or victim(s) of the crime, the description, identity or location of the person who committed the crime).
6. **To avert a Serious Threat to Health or Safety**. We may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosure to a person or organization able to prevent the threat.
7. **For Military Functions/National Security.** Your PHI may be disclosed if you are a member of the US or foreign military forces and if required to by the appropriate military command authorities. We may also disclose PHI about you to federal officials for intelligence and national security activities authorized by law. We may also disclose PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates.** We may disclose PHI to a correctional facility if you are an inmate or under the custody of a law enforcement official.

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain.

1. **Right to Request Confidential Communication**
2. **Right to Request Restrictions in use of your PHI**
3. **Right to Inspect and Copy your PHI**
4. **Right to Request Amendment to your PHI**
5. **Right to an Accounting of Disclosures**

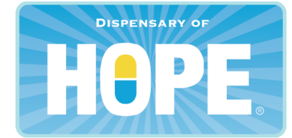
We are not required to agree to your requests, but will do everything within our means to accommodate any legitimate request.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH THE DISPENSARY OF HOPE'S PRIVACY OFFICER, OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

To file a complaint with us, you must submit in writing to the address listed at the end of this Section. **We will not retaliate against you for filing a complaint.**
If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

The Dispensary of Hope
P.O. Box 281496
Nashville, TN 37228
Telephone (615)736-5075
Or
The Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 202

Dispensary of Hope Continued Access Program



Patient Enrollment Form

P.O. Box 281496, Nashville, TN 37228, Phone: (888) 428-4673, Fax: (615) 736-5624

Most medications require the following baseline criteria for enrollment in the Dispensary of Hope Continued Access Program:

1) * Patient's total gross household income is at or below 200% of the Federal Poverty Level *(See grid)*
2) Patient is a U.S. citizen
3) Patient is not enrolled in Medicaid, Medicare Part D and does not have third party prescription insurance
   - If Patient is under 18, **provide Medicaid denial letter**
   - If Patient is 65 or above, **provide SSI low subsidy denial letter**

*** Some medications extend eligibility beyond that listed. Please call 1-888-428-4673 to check the eligibility criteria of your medication.**

Household Size	Income Criteria (200%FPL)		
	Annual	Monthly	Weekly
1	$21,780	$1,815	$419
2	$29,420	$2,452	$566
3	$37,060	$3,089	$713
4	$44,700	$3,725	$860
5	$52,340	$4,362	$1,007
6	$59,980	$4,999	$1,154
7	$67,620	$5,635	$1,301
8	$75,260	$6,272	$1,448
For families with more than 8 persons, add $3,820 for each additional person			

Patient Information

First Name:	Last Name:	MI:	Social Security Number:

Street/Shipping Address (no P.O. Box) :	Phone:	Birth Date:	Gender (m/f):

City:	State:	Zip Code:	County:	Number in Household:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Medication Allergies (y/n): ☐ Yes ☐ No	If yes, list all allergies:	How did you hear about the Dispensary of Hope?

Check all medical conditions that apply:

- ☐ **Acid Reflux/GERD**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Coronary Artery Disease/ Heart Failure**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Emphysema/COPD**
- ☐ **High Cholesterol**
- ☐ **Hypertension (high blood pressure)**
- ☐ **Hypo Thyroid**
- ☐ **Hyper Thyroid**
- ☐ **Seasonal Allergies**
- ☐ **Seizures**
- ☐ **Other** ___________________________

Prescriber's Information

Prescriber's Name:	Address:		Phone:
Office/Clinic Name:	City:	State:	Zip Code:

Shipping Preference

What is the preferred shipping location for prescriptions? ☐ **Prescriber's Office** ☐ **Patient's Home**

Please Note: The Dispensary of Hope cannot guarantee medications will be shipped to the preferred location, but we will do our best to meet this request.

Payment Information

Payment Method: ☐ **Cashier's Check** ☐ **Money Order** ☐ **Credit Card** (If paying by credit card complete the information below)

Card Type: ☐ **Visa** ☐ **Mastercard**	**Name on Card:**
Card Number: ________-_________-_________-________	**Billing Address:**
Expiration Date: ______/_______/__________	**Billing City:** **Billing State:**
Security Code: *(3 digits on back of card)* _________	**Billing Zip Code:** **Phone:**

Eligibility Information

Please check if Patient has: ☐ **Medicare** ☐ **Medicaid** ☐ **VA Health Benefits** ☐ **Health Insurance (with RX coverage)** ☐ **Health Insurance (without RX coverage)** ☐ **No Health Benefits**

Include ALL Income *– social security, pension, disability, retirement, child support, alimony statement, worker's comp, unemployment etc.*

	Name	Relationship to Patient	Amt. of Income	Frequency of Income *Ex. once/yr, biweekly*	Type of Income *Ex. disability, social security, pension, alimony, worker's comp*
1		*Patient*			
2					
3					
4					
5					
6					

Statement of Consent and Release

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to the Dispensary of Hope and/or their agents. I authorize the Dispensary of Hope and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Dispensary of Hope program, which may include sharing of data for auditing and verification purposes, contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities the Dispensary of Hope may deem appropriate to release medical records or required information and to request information for medication reconciliation and/or medication therapy management. I agree that at any time during my enrollment the Dispensary of Hope may request additional documentation to authenticate the statements made on my application and/or to coordinate medication management with me and my healthcare providers. I further authorize to Dispensary of Hope to sign on my behalf as my attorney-in-fact any applications, authorizations or other documents that may be required to effectuate my enrollment and participation in the Dispensary of Hope program. Additionally, I will notify the Dispensary of Hope if I become eligible for Medicare, Medicaid, Health Insurance, VA Benefits, or if there is a change in my financial status.

☐ **I have received the Dispensary of Hope's Privacy Practices Statement** *(See attached)*

Patient/Guardian signature: ____ ***Date:*** _______________

Dispensary of Hope Use Only

Date Application Received:	**Total Household Size:**	**Annual Gross Income:**	☐ **Approved** ☐ **Paid** ☐ **Denied (reason)** ________________________		
Dispensing Site: *DS080- Out of Network*		**Unique Patient ID:**	**eHope Patient ID:**	**Eligibility Start:**	**Eligibility End:** **DOH Initial:**