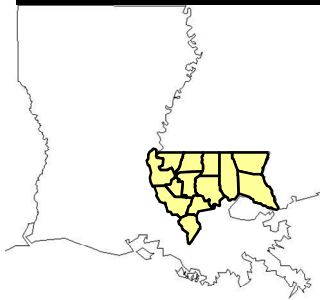




CAPITAL AREA AGENCY ON AGING



Toll free: 1-800-280-0908
Phone: 225-287-7414
Fax: 225-287-7418

P.O. Box 66038
Baton Rouge, LA 70896
www.capitalaaa.org



Dear Sir or Madam:

Thank you for your interest in the Louisiana SenioRx Program. Enclosed are the enrollment forms you need for SenioRx. Please complete these forms and return them with **copies of the documents listed below:**

- Medicare Card (front and back) if applicable
- Proof of Income (Social Security benefit letter, copy of recent income tax return, W-2 forms, yearly interest income statements, pension benefits statement, etc)
- Insurance Cards (front and back)

The SenioRx program can only assist you with medications that are taken on a monthly basis for chronic conditions. Please fill out these forms completely. You should list only the medications that you are NOW taking. This list should include name of drug, strength, how often taken, and the name, address and phone number of the prescribing physician. Failure to include ALL requested information (except drug manufacturer) will cause your application to be delayed or returned to you.

If you have any questions, please call our office at (225) 287-7414 in Baton Rouge or 1-800-280-0908 if you're outside the Baton Rouge area. We look forward to helping you get your medications for free or at reduced prices.

Sincerely,
The Capital Area Agency on Aging
Louisiana SenioRx Staff

*The Louisiana SenioRx Program is administered by the Governor's Office of Elderly Affairs.
The information being collected will be kept STRICTLY CONFIDENTIAL.*

Serving Seniors Since 1974

EQUAL OPPORTUNITY EMPLOYER





Please complete and return to: Louisiana SenioRx Program
P.O. Box 66038
Baton Rouge, LA 70896-6038

CLIENT APPLICATION

Social Security Number: Medicare Number:
Last Name: First Name: MI:
Mailing Address: Street Address:
City: Zip: Parish: Home Phone:
Race/Ethnicity: White African American Hispanic Other
Gender: Male Female Birth date: Rent Own Other
Emergency Contact:
Name: Address:
Phone: Relationship:
Did you file income taxes last year? Yes No Are you a legal U.S. resident? Yes No
Employment Status: Retired Disabled Full time Part time
Are you a veteran or veteran's spouse/widow? Yes No
Marital Status: Married Single Widowed Spouse's Name:
Spouse's Social Security Number: Number living in household (including client):

ATTACH COPIES OF YOUR PROOF OF INCOME (SOCIAL SECURITY LETTER or W2)
(We must have a copy of proof of income for everyone in your household)

TOTAL MONTHLY INCOME \$ TOTAL ANNUAL INCOME \$
Salary/Wages \$ Unemployment \$ Social Security Disability \$
Veteran's Benefits \$ Child Support \$ Social Security \$
Workman's Comp \$ Pension \$ SSI \$
Railroad Retirement \$ Interest Income \$ Other (i.e. public assistance) \$

MEDICAL INFORMATION

ATTACH COPY OF INSURANCE CARD WITH APPLICATION (FRONT and BACK)

TOTAL MEDICAL EXPENSES \$ (over-the-counter medicines, copays, supplies, doctor visits, etc.)
PRESCRIPTION DRUG COSTS \$ (monthly average)
Are you currently enrolled in any prescription assistance or discount programs? Yes No
Do you have insurance covering prescription drugs? Yes No
Have you voluntarily canceled state, federal, or private prescription coverage within six months? Yes No
Are you enrolled in Medicare VA Benefits SLMB QMB #
Do you have any health insurance coverage? Company and Policy #
Do you have a Medicare Supplemental Policy? Company and Policy #

PLEASE LIST YOUR DRUG ALLERGIES:



PATIENT CONSENT AND RELEASE FORM

EXCHANGE OF INFORMATION

I give permission to authorized representatives of the Louisiana **SenioRx** 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 **SenioRx** to discuss my medical needs and me with my physician when necessary. Additionally, I give **SenioRx** permission to verify my income through the Social Security Administration, my employer, Veterans Administration or any other company, business or organization from which I receive income. This authorization is good as long as **SenioRx** is assisting me or until I revoke such.

I want a copy of this form to 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.

DOB: _____ SSN: _____

ADDRESS: _____

FULL PRINTED NAME OF PATIENT: _____

SIGNATURE: _____ DATE: _____

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of Louisiana **SenioRx** to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as **SenioRx** is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: _____

SIGNATURE: _____ DATE: _____

PLEASE LIST ALL MEDICATIONS YOU NEED HELP OBTAINING.

Medication	Directions/Strength	Primary Diagnosis	Prescribing Doctor	Cost
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

PLEASE LIST CONTACT INFORMATION FOR ALL THE PHYSICIANS WHO PRESCRIBE YOUR MEDICATIONS?

Name	Complete Mailing Address	Phone Number
1.		
2.		
3.		
4.		
5.		

I hereby state that the information I have given is correct to the best of my knowledge and the Louisiana SenioRx Program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand that the Louisiana SenioRx Program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services.

Signature: _____ Date: _____



Governor's Office of Elderly Affairs

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 it carefully.

We understand that medical information about you and your health is personal. GOEA, and all Louisiana Area Agencies on Aging and Councils on Aging are required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with a copy of this notice of our legal duties and privacy practices with respect to your health information.

How GOEA, Area Agencies on Aging, and Councils on Aging may use or disclose your health information:

-FOR TREATMENT Information obtained by our agencies will be used to assess your needs and eligibility for nutrition, health, wellness, personal care, medication management, medical alert, material aid, personal care, and counseling services, etc.

-FOR BILLING YOUR INSURANCE We may disclose health information about you during the processing of billing and insurance claims processing, if applicable.

-AS REQUIRED BY LAW We will disclose health information about you when required to do so by federal, state, or local law.

-BUSINESS ASSOCIATES There are some services we offer that are provided through contracts with business associates. We may disclose your information to our business associates so that they can perform the job we have asked them to do: however, we require them to appropriately safeguard your information.

-TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

-PUBLIC HEALTH RISKS We may disclose health information about you for public health activities. These activities generally include the following: (1) to prevent or control disease, injury or disability; (2) to report reactions to medications or problems with medical products; (3) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (5) to notify the appropriate government authority if we believe a person has been the victim of abuse, neglect or domestic violence (we will only make this disclosure if you agree or when required or authorized by law).

-FOR HEALTH OVERSIGHT ACTIVITIES We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor our programs, include audits, investigations, inspections and licensure.

-FOR SPECIFIC GOVERNMENT FUNCTIONS We may disclose health information for the following specific government functions: (1) in response to a request from law enforcement, if certain conditions are satisfied; (2) for national security reasons; and (3) as authorized by and to the extent necessary to comply with worker's compensation and similar laws or programs.

-COMMUNICATIONS WITH CAREGIVERS AND RELATIVES We may use or disclose your information to notify or assist in notifying: (1) a family member, personal representative, or caregiver regarding your location and general condition; (2) a family member, other relative, close personal friend, or any other person you authorize, as necessary for and directly relevant to that person's involvement in your care. Please assign an authorized person here:

Name: _____ Phone Number _____

When GOEA, Area Agencies on Aging, and Councils on Aging may not use or disclose your health information:

Except as described in this Notice, we will not use or disclose your health information without your written authorization. If you do authorize use or disclosure of your health information for another purpose, you may revoke your authorization in writing at any time. If Louisiana law provides additional restrictions upon any of the foregoing uses and disclosures, we must follow state law.

You have the following rights with respect to your health information:

-You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to a restriction that you request. We cannot agree to limit the uses or disclosures of information that are required by law.

-You have the right to inspect and copy your health information as long as we maintain the health information. Simply submit a written request to us. We may charge you a fee for the costs of copying, mailing or other supplies that are needed to grant your request. We may deny your request in certain limited circumstances.

-You have the right to request that we amend your health information that is incorrect or incomplete. To request an amendment, submit a written request to the servicing agency, along with the reason for the request. We are not required to amend health information that is already accurate and complete.

-You have a right to receive an accounting of disclosures of your health information we have made for purposes other than disclosures (1) you have requested or authorized, and (2) for certain government functions. To request an accounting, you must submit a written request that specifies the time period you choose.

-You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about health matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must submit a written request to the Council on Aging location providing services. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

For more information or to report a problem:

If you have questions or would like additional information about our privacy practices, you may contact the Louisiana Governor's Office of Elderly Affairs at PO Box 80374, Baton Rouge LA 70898-0374 or 225.342.7100. If you believe your privacy rights have been violated, you can file a complaint with the Office of Elderly Affairs at the above address. There will be no retaliation for filing a complaint.

I have received a copy of the GOEA Privacy Notice:

Client Signature _____ Date _____

Agency issuing notice: Capital Area Agency on Aging
P. O. Box 66038, Baton Rouge, LA. 70896-6038
(225) 287-7414 1-800-280-0908