P.O. Box 66038, Baton Rouge, LA 70896-6038

CAPITAL AREA AGENCY ON AGING

Carrollton Office Building
6554 Florida Boulevard, Suite 221
Baton Rouge, LA 70806
Telephone: (225) 287-7414
1-800-280-0908
Fax: (225) 287-7418
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)
- Copy of Insurance Explanation of Benefits or Pharmacy Print-Out (beginning this year to current date) if you have prescription drug insurance.

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 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 or1-800-280-0908 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.

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

CLIENT APPLICATION

Social Security Number: _____ Medicare Number:_____
Part A Effective Date:_____ Part B :_____
Last Name:_____First Name:_____ MI:_____
Mailing Address:_____ Street Address:_____
City:_____Zip_____Parish:_____Home Phone:_____
Race/Ethnicity: White___African American____Hispanic:_____Other: _____email_____
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 US resident? Yes ____No _____
Employment Status: Retired:____Disabled_____Work 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):____
Spouse's birth date:_____

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 $_____Interest Income $_____
Railroad Retirement $_____Other (i.e. public assistance) $_____

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

Are you currently enrolled in any prescription assistance or discount programs? Yes ___No ___
Do you have insurance covering prescription drugs? Yes ____ No ____
Did you voluntarily cancel state, federal or private prescription coverage in 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 Advantage or Medigap Policy? Company and Policy # _____

PLEASE LIST YOUR DRUG ALLERGIES:_____
_____

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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 theSocial 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.

DATE OF BIRTH _____SOCIAL SECURITY NUMBER _____
ADDRESS _____
FULL PRINTED NAME OF PATIENT _____

SIGNATURE _____DATE _____

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of Louisiana **SenioRx** (Robbie Mayberry, Beryl Mitchell or Judy Vercher) 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 CLIENT _____

SIGNATURE _____DATE_____

PLEASE LIST ALL MEDICATIONS YOU NEED HELP OBTAINING

Medication	Directions/Strength	Primary Diagnosis	Prescribing Doctor
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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

Name	Complete MailingAddress	Phone Number
1.		
2.		
3.		

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 FUNCITONS 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
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