Louisiana SenioRx
Linking Seniors to Pharmaceutical Aid

Louisiana SenioRx
c/o Jefferson Council on Aging, Inc.
6620 Riverside Drive, Ste. 107
Metairie, LA 70003

Fax (504) 371-5353
Toll free 1-866-865-7975

(504) 207- 4699

Dear SenioRx Participant:

Thank you for your interest in the Louisiana SenioRx Program.

Enclosed are the enrollment forms for SenioRx. If you need assistance, or have any questions, you may call us or have a friend or relative call for you. However, failure to include ALL requested information (except drug manufacturer) will cause your application to be returned to you.

You should list only the medicines that you are NOW taking. You must also call us whenever your doctor changes any of your medications. Please remember to call us once you receive your medications.

If you have any questions, please call our office at (504) 207- 4699.

Sincerely,

SenioRx Staff

Louisiana SenioRx
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Metairie, LA 70003
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FREQUENTLY ASKED QUESTIONS

- **SenioRx does not supply your medications.** SenioRx provides assistance for applying for discount pharmaceutical cards and pharmaceutical free drug programs, as well as applying for refills once initial assistance is obtained.

- Each drug company has individual requirements for eligibility. **SenioRx cannot guarantee that you will receive all medicines requested, but will help you apply for all medicines when you meet the companies' guidelines.** You must supply all information requested to finish your application in a timely manner.

- There is **no charge for you to participate** in the SenioRx program, but **voluntary contributions to help support the program are gladly accepted.**

- **You will be expected to provide personal information needed** to complete the process, including your doctor's signature and an original prescription (if needed) for the application.

- It usually takes between **6 to 8 weeks to receive your medication or pharmaceutical discount card after mailing off your application.** For pharmaceutical free drug programs, most drug companies mail the medicine directly to your doctor—the medicine will not be distributed by the SenioRx Program. If you apply for a drug discount card, it will be mailed directly to you.

- **All information collected to complete your application will be kept strictly confidential.**

Please complete & return by mail or fax to:
Louisiana SenioRx - JCOA
6620 Riverside Drive, Ste. 107
Metairie, LA 70003

Fax (504) 371-5353 Office(504) 207- 4699

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 Are you a veteran or veteran's spouse/widow?

____Full time ___Part time ____Yes ____No

Marital Status: ___Married ___Single ___Widowed Spouse's Social Security Number: ________________

Spouse's Name: ___________________ Number living in household (including client): _____

ATTACH PROOF OF INCOME (copies of Soc. Sec. Award Letter or Tax Return - IRS Form 1040 for self & spouse)

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) $______

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 # ____ QI - 1 ____

Do you have any health insurance coverage? ____
Company Policy #

Do you have Medicare Supplemental Policy? ____
Company Policy #

Are you in the Medicare Part D GAP or "Doughnut Hole"? ___Yes ___No

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

PLEASE LIST ALL MEDICATIONS YOU NEED HELP OBTAINING				
Medication	**Primary Diagnosis**	**Directions/Strength**	**Prescribing Doctor and Phone**	**Manufacturer and Cost**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
20.				

PLEASE LIST YOUR DRUG ALLERGIES: ____

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PLEASE LIST CONTACT INFORMATION FOR ALL THE PHYSICIANS WHO PRESCRIBE YOUR MEDICATIONS?		
Name	Address	Phone Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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: ______________

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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 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: ____________________

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SenioRx Program Reminders

Thank you for allowing us to help you with your medication needs. We hope this service will be of great benefit to you.

Just a couple of reminders:

1. All personal information will be kept strictly confidential.

2. You will be mailed your completed pharmaceutical application to sign. You will be required to obtain your physician's information and signature if necessary.

3. Please remember that each pharmaceutical company has individual requirements for eligibility. SenioRx cannot guarantee that you will receive all medications requested and we may ask you to provide more specific information.

4. Most of the pharmaceutical companies mail the free prescription medications directly to the physician for distribution. You will be notified when your medications arrive at your physician's office. Discount drug cards will be mailed directly to you.

5. Please contact your local SenioRx coordinator at the number listed below if you have not received your medications within 2 months after signing your final pharmaceutical applications.

6. **Please let SenioRx know when you receive your first medication**. This begins the process for obtaining your refills.

7. You will also need to call SenioRx **at least 30 days before your medication runs out to complete the refill process.** Depending on manufacturer, some clients will be able to request their own refills. A reminder sheet will be provided for those clients that can do so.

Please let us know if we can be of further assistance.

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serving St. Charles, St. John, St. James, and Jefferson Parishes
Office (504) 207- 4699 TeleFax (504) 371-5353

Please complete and return with application to:

Louisiana SenioRx c/o Jefferson Council on Aging, Inc.
6620 Riverside Drive, Ste. 107
Metairie, LA 70003

CLIENT CHECKLIST

This application packet should be mailed back to Louisiana SenioRx Program address listed above with **ALL** the requested information. **Please verify that you have attached each item by filling out the check list, then sign and return with your application.**

____ Completed application

____ Completed and signed “Patient Consent and Release Form”

____ Proof of income for each member of household (current tax form, Social Security Benefit letter or current bank statement)

____ List of medications and all physician information required on application

____ Proof of insurance (copy of cards – front & back)

____ Jefferson Council on Aging, Inc./Governor’s Office of Elderly Affairs Notice of Privacy Practices ***(Complete front & back and return only one copy)***

I understand that failure to include all requested information will delay completion of my application.

Signature: ___________________________________ Date: _____________

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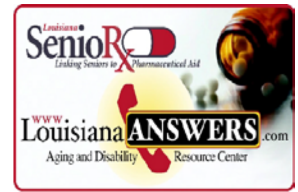

Governor's Office of Elderly Affairs

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, 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:	Jefferson Council on Aging	**AAA/COA**
	6620 Riverside Drive, Ste. 107 Metairie, LA 70003	**Address**
	(504) 888-5880	**Telephone Number**