Patient Enrollment Application

Thank you for your interest in the MedAssist program. Please complete the enclosed application and return it to MedAssist along with the required documents.

Upon receipt of your completed application, MedAssist staff will determine if you are eligible for financial assistance based on our program guidelines and subject to available funding. Please understand that all approvals are based on available funding and are on a first-come-first-served basis.

Please send complete application packet to:

Fax: (408) 885-4093

Mail: Attn: MedAssist
777 Turner Dr, Suite 330
San Jose, CA 95128

Email: MedAssist@hhs.sccgov.org

Drop off: Any Santa Clara Valley Healthcare Outpatient Pharmacy

VALLEY HEALTH CENTER BASCOM
750 S. Bascom Avenue
San Jose, CA 95128
(408) 885-2320

VALLEY HEALTH CENTER GILROY
7475 Camino Arroyo
Gilroy, CA 95020
(408) 852-2212

VALLEY HEALTH CENTER MOORPARK
2400 Moorpark Ave
San Jose, CA 95128
(408) 885-7675

VALLEY HEALTH CENTER DOWNTOWN
777 E. Santa Clara Street
San Jose, CA 95112
(408) 977-4500

VALLEY HEALTH CENTER LENZEN
976 Lenzen Ave,
San Jose, CA 95126
(408) 792-5170

VALLEY HEALTH CENTER SUNNYVALE
660 S. Fair Oaks Avenue
Sunnyvale, CA 94086
(408) 992-4830

VALLEY HEALTH CENTER EAST VALLEY
1993 McKee Road
San Jose, CA 95116
(408) 254-6340

VALLEY HEALTH CENTER MILPITAS
143 North Main Street
Milpitas, CA 95035
(408) 957-0919

VALLEY HEALTH CENTER TULLY
500 Tully Road
San Jose, CA 95111
(408) 817-1360

VALLEY SPECIALTY CENTER
751 S. Bascom Ave
San Jose, CA 95128
(408) 885-2310

O'CONNOR OUTPATIENT PHARMACY
2101 Forest Ave
San Jose, CA 95128
(408) 947-2988

Please contact us if you have any questions or need assistance filling out the application form.

Phone: (408) 970-2001
Email: MedAssist@hhs.sccgov.org
Hours: Monday – Friday, 9AM – 5PM
www.GetMedAssist.com

Getting Started

What Information Do I Need?

1. Patient contact and demographic information
2. Prescription information
    a. Medication name
    b. Copy of prescription **OR** pharmacy information
3. Financial information
    a. Estimate of annual gross household income and household size
    b. Estimate of out-of-pocket healthcare expenses from previous calendar year
    c. Out-of-pocket healthcare expenses from previous calendar year. Out-of-pocket healthcare expenses include:
        - Medical and prescription co-payments
        - Insurance premiums

What Documents do I Need?

Proof of Residence in Santa Clara County – Provide **ONE** of the following:

- Current Rental Contract/Lease
- Current Mortgage Statement
- Current Utility Bill (Water, Electric, Gas, Garbage)
- Homeless (Completion of patient statement form)
- Vehicle Registration
- Driver License (Current)
- Letter of support from person with whom applicant is living with and proof of residency for that person

Proof of Identity (Photo ID Required) – Provide **ONE** of the following:

- Valid Driver's License
- Valid Passport
- Valid Government issued ID Card
- Valid Work or School ID Card
- Birth Certificate along with any valid photo identification

Proof of Income – Provide **ALL** that apply **for your entire household** for the previous calendar year:evious calendar year:

- Recent **Tax Return (required)**
- Check Stubs (at least two (2))
- W-2 Form
- Award Letter (Social Security, Disability, Unemployment, Worker's Compensation)
- Cash Income Statements (including tips)
- Military Benefits Statement
- Rental Income Receipts

Proof of valid prescription(s) – Provide ONE of the following for each qualifying prescription:

- Copy of Prescription
- Pharmacy Contact Information

Staff Use Only: Date: _____ Time: _____

Section 1: Patient Information

Legal Last Name:*	Legal First Name:*	Legal Middle Name:

Patient DOB (MM/DD/YYYY):*	Preferred Language:*

Address:*		

City:*	State: CALIFORNIA	Zip Code:*

Home Phone Number:*	Mobile Phone Number:

Email Address:

Gender Identity:*

- ○ Male
- ○ Female
- ○ Transgender Female
- ○ Transgender Male
- ○ Non-binary
- ○ Other

Ethnicity:*

- ○ Not Hispanic or Latino
- ○ Spaniard
- ○ Mexican
- ○ Central American
- ○ South American
- ○ Latin American
- ○ Puerto Rican
- ○ Cuban
- ○ Dominican
- ○ Other Hispanic or Latino
- ○ Decline/Unable to specify

Race:*

- ○ Patient Declined / Unable to Specify
- ○ Asian, Filipino
- ○ Asian, Vietnamese
- ○ White, Arab
- ○ Hispanic or Latino
- ○ Asian, Chinese
- ○ Asian, Laotian
- ○ Asian, Korean
- ○ Asian, Cambodian
- ○ Asian, Japanese
- ○ Asian, Indian
- ○ Asian, Pakistani
- ○ Black, African
- ○ Black, Other
- ○ White, North American
- ○ White, European
- ○ White, Middle Eastern or North African
- ○ Black, African American
- ○ White, Other
- ○ Native American
- ○ Alaska Native
- ○ Asian, Other
- ○ Pacific Islander, Guamanian
- ○ Pacific Islander, Samoan
- ○ Pacific Islander, Hawaiian

How Did You Hear About the MedAssist Program?*

- ☐ Returning Applicant
- ☐ Friend or Family
- ☐ Financial Assistance Counselor
- ☐ Doctor's Office
- ☐ Pharmacy: _____
- ☐ SCVMC website
- ☐ Instagram
- ☐ Facebook
- ☐ LinkedIn
- ☐ Newspaper
- ☐ NextDoor
- ☐ Other (please specify): _____

Section 2: Prescription Information

Please list each of your current prescriptions from the following three (3) medication categories:

- Diabetes medication
- Asthma inhaler
- Epinephrine auto-injector

Prescription 1:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 2:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 3:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 4:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 5:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 6:		
Medication Name:*		
Medication Category: [select one]* ◯ Diabetes medication ◯ Asthma inhaler ◯ Epinephrine auto-injector		
If you are not attaching a hardcopy prescription with this application, please fill out the section below:		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Section 3: Financial Information

Household Size	
Number of people in your household including yourself, your spouse or domestic partner and dependent children under age twenty-one (21), whether living at home or not.	
Income Information	
Total Annual Household Gross Income in the previous calendar year – *combined from all sources** $	
Annual Healthcare Expenses	
Household Healthcare Out-of-Pocket Expenses in the previous calendar year – *this includes your Medical and Prescription Co-payments, Insurance Premiums** $	

COUNTY OF SANTA CLARA
Health System

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1
Patient Name: _____
Date of Birth: _____
ID or Medical Record # _____
Address: _____
_____
Tel: _____

2 AUTHORIZATION: I give permission to My Pharmacy to use and release to
Recipient Name: SCVMC Pharmacy Department
Address: 777 Turner Dr, Suite 330 San Jose, California 95128
Phone: 408-885-2300 Fax: 408-885-5822

3 PURPOSE: The health information disclosed may only be used for the following purpose(s): My enrollment and participation in the MedAssist Program.

4 INFORMATION TO BE RELEASED

A. ☐ Medical Record
- ☐ All health information (e.g. diagnosis, test results, treatment); OR
- ☐ Images and/or Films ☐ Reports ☐ Billing ☐ Dental

B. ☐ HIV/AIDS Test Results (A separate authorization is required for each disclosure.) Initial: ___

C. ☐ Drug & Alcohol Treatment(e.g. diagnosis, test results, treatment, billing, attendance) Initial:___

D. ☐ Mental Health (e.g. diagnosis, test results, treatment, billing) Initial:___

E. ▣ Other My prescription, billing information, and fill history for all my medications Initial:___

5 DELIVERY PREFERENCE:
▣ Mail ☐ Pick up ▣ Other Phone, Fax, Email

6 DELIVERY FORMAT:
☐ CD ☐ Film ▣ Paper ▣ Other Electronic

7 DURATION: This authorization is valid immediately and will be valid until 12/31/2035 (*give date*). If I do not write in a date, it will expire twelve months from the date it was signed.

8 CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128 and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by CSCHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10 REDISCLOSURE: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

11 Patient/Patient's Representative Name Patient/Patient's Representative Signature Relationship Date

COUNTY OF SANTA CLARA
Health System

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge you have received a copy of our ***Notice of Privacy Practices.*** Our ***Notice of Privacy Practices*** gives you information about how we may use and disclose your medical or protected health information (PHI). Please read it carefully.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, we will post the revised version in our facilities. You may obtain a copy of the latest ***Notice of Privacy Practices*** from our Registration or Admitting staff when you come to any of our facilities for services or treatment.

I hereby acknowledge receipt of the ***Notice of Privacy Practices*** of County of Santa Clara Health System (CSCHS).

Date: _____ Signature: _____
(patient/parent/conservator/guardian)

Name: _____
(please print)

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INABILITY TO OBTAIN ACKNOWLEDGEMENT

This portion must be completed only if no signature can be obtained. If it is not possible to obtain the individual's acknowledgement, describe good faith efforts made to obtain the acknowledgement, and the reasons why the acknowledgement could not be obtained.

Date: _____ Signature: _____
(Representative of CSCHS)

Title: _____

Terms and Conditions of Program Participation

1. Patient has applied, or Patient's legal representative (e.g., parent or legal guardian) has applied on Patient's behalf, to participate in the MedAssist program. If the Patient meets eligibility criteria based on information provided in the application and funds are available, the Patient or Patient's legal representative will be awarded a grant to assist with out-of-pocket healthcare expenses such as copayments, coinsurance, deductibles, and/or insurance premiums.
2. Receipt of the MedAssist grant is contingent upon Patient filling and using their qualifying prescription(s) as prescribed.
3. Patient or their legal representative understands that any false or information provided on the MedAssist application could lead to revocation of the grant at any time and furthermore may constitute fraud for which the Patient or their legal representative may be legally liable.
4. If MedAssist becomes aware of any inaccurate information or fraudulent activity relating to the Patient's application and the application is approved, participation in the program will terminate and MedAssist may recoup the amount of financial assistance provided to the Patient or their legal representative.
5. Patient or their legal representative authorizes SCVHHS to request a credit report and/or to verify any of the information provided in the application as deemed necessary.
6. MedAssist has the right at any time, without notice to Patient or their legal representative, to modify or discontinue all or any part of the MedAssist program and/or Grant.
7. Patient or their legal representative is not guaranteed or promised financial assistance, and that any assistance provided by MedAssist is limited to the terms and conditions established by MedAssist.
8. Patient or their legal representative agrees to notify MedAssist in writing within 14 calendar days via email (medassist@hhs.sccgov.org) or mail (777 Turner Dr, Suite 330 San Jose, CA 95128) of any failure to comply with any of these Terms and Conditions of Program Participation or any change in the following information:
    a. Personal information: home address, phone number, e-mail address, contact information
    b. Household information: had another child or adopted a child, child moves in or out of the home, death in the family, got married, getting divorced, legally separated, have a registered domestic partner
    c. Job status: became unemployed, salary changed, got an extra job, spouse employment or salary changed
    d. Income: income changes, investments or assets change, got an inheritance or pension, bought or sold property
9. If you are applying for yourself or on behalf of someone else, you and the individual you are applying for must reside in Santa Clara County. You must notify MedAssist in writing within 14 calendar days via email (medassist@hhs.sccgov.org) or mail (777 Turner Dr, Suite 330 San Jose, CA 95128) of any change in residence.

☐ I have read and agree to fully comply with the Terms and Conditions of Program Participation. I understand that failing to do so may lead to termination of participation in the MedAssist program.

I certify under penalty of perjury by my signature that the information I have provided as required in this agreement is true and complete to the best of my knowledge and belief.

Patient Name

Patient's Legal Representative Name
(if signing on behalf of Patient)

Patient or Legal Representative's Signature

Legal Representative's Relationship to Patient

Date

MedAssist Program
777 Turner Dr, Suite 330
San Jose, CA 95128
Tel: 408-970-2001
Fax: 408-885-4093

DATE:

TO:

REFERENCE #:

FROM: MedAssist Program

SUBJECT: Quarterly MedAssist Attestation

Please complete the attestation and questionnaire to get your next grant payment. Your questionnaire responses may be shared with a pharmacist. Your payment will be processed after the attestation and questionnaire are received.

By signing below, I acknowledge that:

1. I have been given a grant through the MedAssist program, and I know that if the qualifying prescriptions are refilled regularly and on time AND I take the medications as prescribed, I will get my grant money every month.

2. In the past 90 days, the qualifying prescriptions have been refilled regularly and on time AND I have taken the medications as prescribed.

3. I attest that the qualifying prescriptions will continue to be refilled regularly and on time AND I will continue to take the medications as prescribed for the next 90 days.

4. I will notify MedAssist within one (1) week of any failure to comply with program requirements and any change that may affect my eligibility to participate in MedAssist, such as household information, job status, and/or income.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Patient/Patient's Representative Name	Patient/Patient's Representative Signature
Relationship to Patient	Date

Clinical Questionnaire

Initial Application:

Have you gone to the Emergency Room (ER) in the last three months because you didn't take your medication(s)?	○ Yes	○ No	
Have you missed any doses of your medication(s) in the last three (3) months?	○ Yes	○ No	○ N/A
If you have asthma, do you feel your asthma has been well controlled in the last three (3) months?	○ Yes	○ No	○ N/A
If you have diabetes, do you feel your diabetes has been well controlled in the last three (3) months?	○ Yes	○ No	○ N/A
If you have severe allergies, do you feel confident about using epinephrine auto-injector (EpiPen) at the time of need?	○ Yes	○ No	○ N/A