The Maksoud Foundation

Patient Assistance Program Application

The Maksoud Foundation is an independent, non-profit organization that is committed to helping eligible patients without insurance coverage or adequate insurance coverage receive donated prescription products.

You may be eligible for our prescription assistance program for up to 180 days if you meet the requirements below:

- You have been prescribed a Community Care Rx company donated medication
- You meet the eligibility income requirements for the medication(s)
- You do not have insurance or medicine is not covered
    - Some patients with Medicare Prescription Drug Coverage (Part D) who cannot afford their medicines and who meet certain financial criteria may also be eligible for assistance
- You live in the United States or a U.S. territory
- You are being treated by a U.S. licensed doctor as an outpatient

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TO BE COMPLETED BY THE PATIENT

1 Patient Information

Name: _____ Phone: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address (Street, City, State, ZIP): _____

2 Financial Information

Total Gross Yearly Income
Entire household: $ _____

Household Size
Including yourself, the number of people who live in your home and are dependent on your household income: _____

3 Healthcare Insurance Information *(Select all that apply.)* **Please attach a copy of your insurance card.**

Subscriber Name: _____ Date of Birth: _____ Relationship to Patient: _____

Primary Plan Name: _____ Secondary Plan Name: _____

☐ Check if no insurance	ID/Policy #	Group #	Phone
☐ Prescription Insurance/Medicare Part D Plan Plan Name: _____ Fax: _____ Rx BIN #: _____ Rx PCN: _____			
☐ Private/Commercial Insurance			
☐ Medicaid			
☐ Medicare Part B			
☐ Medicare Advantage			
☐ Veterans Administration			
☐ ADAP AIDS			
☐ SPAP State Patient Assistance Program			
☐ Other:			

4 Patient Declaration/Authorization to Assign Representative for Program Enrollment

Signature and date required before submission.

My signature below indicates that I have read, understand, and agree to the Patient Declaration and Patient Authorization to Share Health Information. If I have listed an authorized representative below, I permit the Foundation to discuss my application with this person. This includes the status of my application, insurance and financial questions, any missing documentation, and other issues related to my application and participation, throughout my enrollment period in the program. By signing below, this representative is allowed to speak on my behalf regarding my application.

PLEASE COMPLETE, SIGN & DATE:

Patient Name *(print)*: _____ Date: _____

Authorized Representative Name *(print if applicable)*: _____

Relationship to Patient *(print if applicable)*: _____ Phone: _____

_____ Date: _____

Patient Signature/Authorized Representative

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PATIENT DECLARATION AND PATIENT AUTHORIZATION TO SHARE HEALTH INFORMATION

Please read, sign and date on page 2.

I promise:

- The information on this form is correct and complete including all copies of documents proving my income.
- The product(s) provided under this patient assistance program will not be sold or traded.
- I will notify the Patient Assistance Program ("Program") within thirty (30) days if there is any change in the status of my eligibility (related to changes in income or health coverage) to receive products through this program. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D.
- Not to attempt to claim or submit any costs associated with the medicine(s) I receive under the Foundation Patient Assistance Program to any person or entity, including my Medicare Part D plan.
- Not to seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program.

I authorize the following communications:

- Specifically, I authorize to contact me to request my assistance with analysis related to the quality and efficacy of the Program.
- When signing this application, I am agreeing to allow the agent to contact me or my healthcare provider for additional information, if needed, to evaluate any adverse event or product complaint I or my provider reported on my behalf.
- The Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers, or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my Program application or information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.

I understand that the vendors associated with administrating the Program (collectively the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or terminate my enrollment at any time, without notice.
- May request and obtain information about my or my family's income, including verification of my income through third-party sources.

Patient Authorization To Share Health Information: By signing on page 2, I hereby authorize:

- My doctor(s), pharmacy and other healthcare providers, and my health plan or insurers ("Entities") to disclose to and share with the Program Administrators and their affiliates, agents, contractors, representatives, service providers, and assignees (" Recipients"), my individually identifiable health information, which may include my full name, demographic information, financial information, and information related to medical condition, treatment, care management, health insurance and benefits, medication history, and prescriptions (collectively, "Health Information"), whether in written or verbal form, including portions of my medical record.
- The Recipients to access, obtain, use, disclose, receive, and maintain my Health Information for purposes of processing this Application, verifying the information provided in this Application, assisting in the identification of or determining eligibility under the Program and other patient assistance resources, investigating and verifying my insurance benefits, coordinating the dispensing and delivery of medication, and conducting the additional services described above and to run the Program, including internal business purposes.

In addition, by signing on page 2, I understand and agree that:

- I may refuse to sign the form on page 2. This authorization is voluntary, but if I refuse to sign this form, I know that this means that I may no longer be eligible to receive assistance from the Program. I understand that my doctor(s), pharmacy and other healthcare providers, and my health plan or insurers may not condition the provision of my treatment, or coverage of my benefits, on my signing this authorization.
- Health Information released under this authorization may no longer be protected by state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA).
- The information provided in this application may be subject to random audits and verification, and that during such audits and verification processes, I may be asked for additional supporting documentation and will comply with such requests.
- I may withdraw my authorization at any time however, such withdrawal will not have an impact on any actions that have already been taken in reliance on this authorization.
- This authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.
- I have a right to receive a copy of this authorization.

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