



THE MEDICINE CABINET

Medication Assistance Program

THE MEDICINE CABINET and your physician work together to provide assistance with over 4,300 commonly prescribed medications. With our program, you will receive a continuing **three-month** supply of your medications for the length of your membership. The medication will be delivered to either your home or your doctor's office. If you do not have a doctor, please contact our office for a list of participating primary physicians.

Checklist for submitting application:

- Ensure all sections of the application are completed. Any missing information will delay your enrollment process.
- Attach proof of income for entire household:
 - Tax Forms
 - 1040, W-2, 1099, or Schedule C
 - Paycheck Stubs (for the past **MONTH**)
 - Social Security/ Disability Statement
 - Unemployment Benefit Statement

Total number of people in household	1	2	3	4	5
Current Annual Income	\$21,660	\$29,140	\$36,620	\$44,100	\$51,580

- Attach a copy of your state I.D. and Social Security Card. If you do not have a Social Security Card, please attach an alternate proof of identification.
- Sign all document where indicated
- Money order written to THE MEDICINE CABINET in the amount of \$50 for enrollment.

Mail completed application, documentation, and payment to:

**The Medicine Cabinet
1805 S. Eastern Ave.
Las Vegas, NV 89104**

Phone: (702) 444-6082

Upon receipt of application, documentation and payment, approval documents will be sent your prescribing physician to begin the enrollment process. If eligible for assistance, a supply of the medications will be delivered your prescribing physician's office. It is your physician responsibility to notify you when your medication has arrived.

For additional information, please contact us at (702) 444-6082 Mon-Fri 9am-5pm PST



The Medicine Cabinet, Inc APPLICATION

The Medicine Cabinet • 1805 S Eastern Ave. • Las Vegas, NV 89104
Phone (702) 444-6082 Fax (702) 650-2184

*All questions **must** be answered; any missing information will delay the enrollment process.

Member Information

Full Name: _____ Gender: Male Female
First M.I. Last

Home Phone: () - _____ Cell Phone: () - _____ Best number to call? Home Cell
Circle One

Address: _____
Street Address Apartment/ Unit #

_____ City State ZIP Code

DOB: / / Soc. Sec. # - - VISA/ GREEN CARD # : _____

Marital Status: Single Married Divorced Widow

Race (Optional): African American Asian/Pacific Islander Caucasian Hispanic Native American Other

Are you a CITIZEN of the United States? YES ___ NO ___ Are you a RESIDENT of the United States? YES ___ NO ___

Are you a Military/Army Veteran? YES ___ NO ___ Are you 65 year old or older? YES ___ NO ___

Do you have any private insurance? YES ___ NO ___ If yes, Do you have **prescription** coverage? YES ___ NO ___

Are you eligible for Medicare Part D? YES ___ NO ___ If yes, Have you enrolled/applied for Part D? YES ___ NO ___

Are you LEGALLY disabled? YES ___ NO ___ If yes, Have you been disabled for more than 2 years? YES ___ NO ___

Have you ever been enrolled in a patient assistant program for your prescription medications? YES ___ NO ___

What condition(s) are you currently being treated for? _____

Household Information

Monthly **HOUSEHOLD** Income: \$ _____ **Proof of income is required** (Paycheck stubs, SSI statement, etc)

Source of income: Wages ___ Social Security ___ Disability ___ Retirement ___ Unemployment ___ Other ___

Did you file taxes for the previous year? Yes No

**If you filed taxes, we will need a copy of your most recent tax return (1040, 1040EZ, 1099, or 4506T)

Household size (including yourself): Circle one: 1 2 3 4 5 6 7+

Doctor Information

Full Name: _____
First Last

Address: _____
Street Address Suite #

_____ City State ZIP Code

Office: () _____ Fax: () _____

***If you have more than one doctor that prescribes medications, please add on reverse side.

I certify that my answers are true and correct to the best of my knowledge. I also understand that the information given to THE MEDICINE CABINET does not and will not guarantee qualification into any assistance program.

Signature of person completing application _____ Date _____

Medication List

Medication Name

Dosage (mg)

Directions (How often?)

Prescribing Doctor

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

9 _____

10 _____

11 _____

12 _____

13 _____

14 _____

15 _____

PLEASE LIST ANY ALLERGIES:

No Known Allergies

1. _____

2. _____

3. _____

MEMBERSHIP AND FEE AGREEMENT

DISCLAIMER:

I. It is our intent to offer the very best service in our endeavour to assist our members with free or low cost medications as requested by their physician. The information provided by "THE MEDICINE CABINET" is not to replace the relationship that exists between the member and his or her physician or make medication suggestions. We are not a physicians nor are we pharmacists and do not act in such manner. All advice of this nature must be obtained form your physician.

II. Our services include assisting the member by furnishing the necessary forms and documents requested by the various pharmaceutical companies as outlined in their individual assistance programs. This will include claim forms, (the prescription section must be completed by your physician), proof of income as specified by the drug manufacturer (also known as the pharmaceutical company) and any other information deemed necessary by the pharmaceutical company to determine eligibility for assistance. All information supplied to "THE MEDICINE CABINET" is held in strictest confidence and will not be supplied to anyone without prior written consent.

III. Acceptance into any "assistance" program is determined by the pharmaceutical company and/or the drug manufacturer not "THE MEDICINE CABINET". At the pharmaceutical company's discretion any "assistance" program can be discontinued at any time without prior notice.

IV. THE MEDICINE CABINET is not responsible for any delay in shipment of medication(s) or the misplacement of medication(s) at your physicians office. It is your (the member's) responsibility to ensure your physician is prepared and willing to accept the shipment of medications on your behalf. Each medication has its own "assistance" program and application process from which it is supplied and all medications will not be delivered or arrive at the same time.

As a member you agree to the following:

- Pay the annual enrollment fee of \$25.00 and the monthly membership fee of \$25.00. Your membership will cover processing of any application into assistance program for brand name medications that (1) are prescribed by your doctor (2) available for assistance and (3) you meet the required minimum qualifications for.
- **Terms:**
 - You will be billed and responsible for the minimum amount of \$25.00 every month for one full calendar year for the total amount of both The Medicine Cabinet and the assistance program fees.
 - If you decide that you will no longer use our services, you will still be held responsible for the payment of the administrative fees for the remainder of your membership term. Failure to pay your balance may and will result in the discontinuance of your medications.
 - In the event of a delay in the shipment of your medication(s) or delivery or your medication(s), you will still be held responsible for the payment of the monthly fee of \$25 for our services.
 - **Delinquency:** After several (3) months of delinquent or non-payment, THE MEDICINE CABINET has the right to remove the member associated with the delinquent account, resulting in the discontinuance of our service which may result in the discontinuance of the shipment of your medications. After the removal, any an all documents will be properly destroyed. Should you decide to re-enroll into this program, you will be required to pay any past due balance before re-enrollment is considered. Re-enrollment will require the signing of a new annual contract and an update of all necessary documents (proof of income, etc.)
 - **Cancellation:** If you acquire prescription coverage while your membership is still active, we will need proof of coverage before you are considered inactive in our program. The only forms of proof that will accepted will be either an active prescription coverage card or an official letter from the insurance company stating that your prescription costs will covered by their program. In that event, this contract will be null and void.
- This contract is valid for one full calendar year effective the date of your enrollment.
- Once your membership term has expired you will be responsible for renewal. Renewal requires a new membership agreement and payment of the annual membership fee.
- **All transactions are final -- no refunds will be given.**
- Terms within this contract are subject to change without prior notice.
- THE MEDICINE CABINET has the RIGHT to refuse service to anyone.
- **Member Responsibility**
 - All applications are to be taken to your doctor's office as soon as possible.
 - The doctor is to fill in and sign all highlighted areas and attached a separate prescription for each medication. If you leave the applications at your doctor's office; it is your responsibility to get those applications back to our office. (The longer it takes to get the applications back – the longer it takes to receive your medications.)
 - Provide The Medicine Cabinet with any and all necessary financial documentations.
 - Notify The Medicine Cabinet of any correspondence received from any pharmaceutical company.
 - Notify The Medicine Cabinet of any household changes.
 - Notify The Medicine Cabinet of any change in medication therapy.

I, _____, UNDERSTAND AND ACCEPT THE MEMBERSHIP AND FEE AGREEMENT.

MEMBER or GUARDIAN SIGNATURE

DATE

OFFICE USE ONLY

Enrollment Date

By

Member #

THE MEDICINE CABINET
PATIENT ASSISTANT PROGRAM

Authorization to Release Information

To Whom It May Concern:

1. I have applied for prescription drug assistance from "The Medicine Cabinet". As a part of the application process, "The Medicine Cabinet" and the pharmaceutical manufacturer may verify information in my application and other documents required in connection with the assistance, either before the assistance is granted or as a part of its quality control program.

2. I authorize you to provide to "The Medicine Cabinet" and to any pharmaceutical manufacturer whom "The Medicine Cabinet" appoints any and all information and/or documentation that they request. Such information includes, but is not limited to; employment history, income information including retirement information (i.e. pension, social security benefits, etc.), bank history, money market and similar account balances, and copies of income tax returns.

3. "The Medicine Cabinet" and/or the pharmaceutical manufacturer may address this authorization to any party named in the prescription assistance program.

Temporary Power of Attorney

1. I _____ give "The Medicine Cabinet" and is representative(s) permission to apply for medication assistance programs on my behalf. "The Medicine Cabinet" will have limited Power of Attorney to sign any necessary paperwork, applications and/ or documentations concerning the assistance programs.

2. I understand that I may revoke my authorization at any time by providing a written request of termination of services with "The Medicine Cabinet"

3. A copy of this authorization may be accepted a an original

Member's Name (Print)

Social Security Number

Member's Signature

Date

Name of Personal Representative (If applicable)

Relationship to Member