Wyoming Medication

Donation Program

Don't let unused medicine go to waste!

Wyoming Medication Donation Program

Wyoming Department of Health,
Pharmacy Services
2508 E. Fox Farm Road, Suite 2A
Cheyenne, WY 82007
(ph) 307-635-1297
(toll free) 855-257-5041
(fax) 307-635-2156

Agency Use:
Referred by:
_____

☐ Wyoming Resident: County of residence_____
☐ Qualifies below 200% of the FPL
☐ No RX Insurance
☐ Medicaid Eligibility verified on: _____
☐ Educated about PAP
☐ Already enrolled; waiting on status

Start date: ___/____/____ End date: ____/____/____

Authorized Representative:
_____
PRINT FULL NAME

PATIENT/CLIENT INFORMATION | **APPLICATION DATE:**

Last Name	First Name (Legal)	Middle Name	Birth Date	Age	Gender M / F

Other Names Used

Mailing Address | City | Zip Code

Home Phone Number	Cell Phone Number	Social Security Number

Race (check one)?
☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ Other

Are you a Veteran? Yes / No

Primary Language (check one): ☐English ☐Spanish ☐Other:

Are you covered by any of the following forms of insurance?

a) Private insurance No ☐ Yes ☐
b) Medicare No ☐ Yes ☐
c) Medicare Part D No ☐ Yes ☐
d) Equality Care Card (Medicaid) No ☐ Yes ☐
e) Kid Care / CHIP No ☐ Yes ☐
f) Prescription coverage No ☐ Yes ☐
g) VA Benefits No ☐ Yes ☐
h) PDAP (3 scripts filled per mo.) No ☐ Yes ☐

Are You a U.S. Citizen? Yes / No

Employment (check one):

☐Full time

☐Part time

☐Unemployed

☐Student

☐Retired

Employer Name: _____

Employer Address: _____

_____

Date Hired:_____

List ***all household members*** by name, gender, birthday, age, race, relationship, and insurance coverage:

Name:	Gender:	DOB:	Age:	Race:	Relationship to applicant:	Insurance Coverage?
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes
_____	M / F	___/___/___	____	_____	_____	No / Yes

List *ALL sources of household income:*

Amount:	Pay frequency:	Employer or source of income:	Paid to:
$ _____	_____	_____	_____
$ _____	_____	_____	_____
$ _____	_____	_____	_____
$ _____	_____	_____	_____

How many people are supported by this income? Adults _____ Children _____

Did you file taxes this past year? No ☐ Yes ☐ If no, when is the last year you filed? _____

Please Provide PROOF OF INCOME FOR ENTIRE HOUSEHOLD
(Such as Pay Stubs for last 30 days, Income Tax return, Social Security Income, Child Support)

Prescription Information

Primary Dr. Name: _____Phone #: (___) _____

Clinic Address: _____FAX #: (___) _____

Medication Allergies:_____

Medication Name	Dose	Directions for use	Reason for use
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Additional Dr. Names: (indicate medication # above that this doctor prescribes; i.e., # 9)
Dr. Name: _____Phone #: (___) _____
Clinic Address: _____FAX #: (___) _____
Medication # from above: _____

My signature indicates that all of the information I have provided is true and correct. I hereby grant permission to this agency to obtain and share the information I have provided for the purpose of determining eligibility for assistance.

I acknowledge that the medication I receive through this program was originally dispensed to another patient and has been donated to the Wyoming Medication Donation Program for re-dispensing.

In accordance with the Drug Donation Program Act and the Administrative Procedures Act W.S. § 16-3-10; I understand that any person or entity which exercises reasonable care in donating, accepting, distributing, dispensing medications under the Drug Donation Program Act or rules and regulations adopted and promulgated under this act shall be immune from civil or criminal liability or professional disciplinary action of any kind for any related injury, death, or loss.

Wyoming Department of Health
Commit to your health.

X_____ _____

Signature (Applicant or Head of Household) Date