Wyoming Department of Health
Commit to your health.

Wyoming Department of Health
Wyoming Medication Donation Program

Instructions for completing Application for Eligibility

1. Complete the enclosed **Application for Eligibility packet**.
2. Include **prescription** information: original prescription, pharmacy information (so that we may transfer refills), or prescriber information (so that we may call for new prescriptions).
3. Include **proof of income** for the **entire** house hold: most recent tax return, paystubs, child support, disability, social security, retirement, etc. If you have no source of income, please include the 'Statement Regarding No Income' form.
4. Include **proof of residency**: utility bill or rent receipt. Driver's licenses are **not** acceptable proof. If you reside with someone else, please include the 'Residence Verification' form.
5. Read the Wyoming Department of Health, Notice of Privacy Practices. Sign and return the **Acknowledgement of Receipt Notice of Privacy Practices**.

Return application and documents....

1. Fax to: (307)-635-2156

   OR

2. Mail to: Wyoming Medication Donation Program
   2508 E. Fox Farm Road, Suite 2A
   Cheyenne, WY 82007

We cannot fill your prescriptions until **ALL** documentation is received. After we receive your complete application, we will fill your prescription for a 30 day supply. The prescription will then be mailed to you. You **MUST** call 1 week in advance for refills.

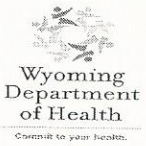
Call if you have questions!

(307)-635-1297 OR Toll Free at (855)-257-5041

www.wyomedicationdonation.org

Monday – Friday 9:00am-3:00pm

Application for Eligibility



Wyoming Medication Donation Program

Wyoming Department of Health,
Division of Healthcare Financing
2508 E. Fox Farm Road, Suite 2A
Cheyenne, WY 82007
(ph) 307-635-1297
(toll free) 855-257-5041
(fax) 307-635-2156
www.wyomedicationdonation.org

Agency Use:
Referred by: _____

- ☐ Wyoming Resident
- ☐ Qualifies below 200% of the FPL
- ☐ No RX Insurance
- ☐ Educated about PAP
  - ☐ Already enrolled; waiting on status

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

Authorized Representative: _____

Patient Information: **Application Date:**

Last Name:	First Name:	Middle Name:	Birth Date:	Age:	Gender M / F
Other Names Used					
Mailing Address:			City:	State:	Zip Code:

*!!! You must provide **proof of residency** with this application (e.g. utility bill, rent receipt, etc.) !!!*

Home Phone Number: ( ) -	Cell Phone Number: ( ) -	Social Security Number: - -

Race (check one): ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ White ☐ 2 or More ☐ Other

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

Insurance Coverage: Are you covered by any of the following forms of insurance?

Private insurance	Yes / No	ID#:	Company:
Medicare Part A / B	Yes / No	ID#:	
Medicare Part D	Yes / No	ID#:	Company:
Equality Care Card (Medicaid)	Yes / No	ID#:	
Kid Care / CHIP	Yes / No	ID#:	
Prescription coverage	Yes / No	ID#:	Company:
VA Benefits	Yes/ No	ID#:	
PDAP (3 scripts per month)	Yes / No	ID#:	

If yes to any of the above, please explain why you are requesting help from the WMDP:

Employment (check one):

- ☐ Full time
- ☐ Part time
- ☐ Unemployed
- ☐ Student
- ☐ Retired

Who referred you to the WMDP (How did you hear about the program)?

List *ALL sources of household income:*

Employer or Source of Income: (Example: Employer, Social Security, Retirement, Unemployment, Child Support, etc.)	Amount:	Pay Frequency: (Example: Weekly, Bi-Monthly, Monthly)	Paid To:
1.	$		
2.	$		
3.	$		
4.	$		

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

!!! ***You must include PROOF OF INCOME FOR ENTIRE HOUSEHOLD with this application*** !!!
(Such as Pay Stubs for last 30 days, Income Tax return, Social Security Income, Child Support, etc.)

Prescription Information:			
Primary Dr. Name:			Phone #: ( ) -
Clinic Address:			FAX #: ( ) -
City:		State:	Zip Code:
Medication Allergies:			

Medication Name and Strength (list *all* meds you take):	Directions for use:	Reason for use:	Assistance/ Source? (Please tell us how you currently access this medication. E.g. Cash (not a copay), insurance copay, PAP, samples, other)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

A valid prescription is required to receive medication from the Wyoming Medication Donation Program.
Choose One:

☐ Original Rx included with the application (faxed copy from a patient is not acceptable)

☐ Please transfer the refill from my local pharmacy- If yes, include Name of Pharmacy: _____
Pharmacy Phone Number: ( ) - _____ Rx Numbers to transfer (separate each with a comma):

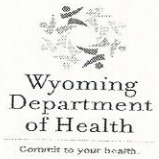
_____

☐ Please contact my prescriber for the prescription- Prescriber Name: _____
Phone Number: ( ) _____
Name of medications requested:

_____

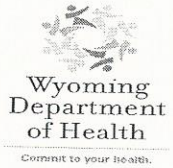
_____

- *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.*



Signature of Applicant: _____ Date: _____

Wyoming Department of Health
Wyoming Medication Donation Program



Statement Regarding No Income

Phone: 307-635-1297
Fax: 307-635-2156

I, _____, am unemployed and do not have any income
(Please print first and last name)

from any source (i.e. unemployment, child support, worker's compensation, sick leave, investments, ect.)

I have funds available to cover my expenses from: (please check all that apply)

_____ Savings _____ Tax Refund _____ Friend/Family _____ Spouse Income

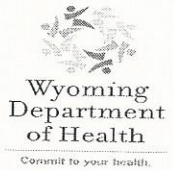
My **HOUSING** expenses are covered by _____
My **FOOD** expenses are covered by _____
My **TRANSPORTATION** expenses are covered by _____
My **OTHER** expenses are covered by _____

_____
Patient Signature

_____
Date

Rev 03.04.2016

Wyoming Department of Health
Wyoming Medication Donation Program



Residence Verification

Phone: 307-635-1297
Fax: 307-635-2156

I, _____, am currently staying with
(Please print name of person applying for Medication Program)

_____ at the this address
(Please print name of tenant/roommate/family member/shelter director/ect.)

_____
(Address of household/homeless shelter, ect., Town/City, State, Zip Code)

_____ _____
Signature of tenant/roommate/family member/shelter director/ect. Date

Phone number of tenant/roommate/family member/shelter director/ect.: (_____)_____

_____ _____
Signature of person applying for Medication Program Date

Proof of residency in the name of the person you are staying with must be provided. Please send **ONE** of the following with your application:

Check one:

- ❑ Utility bill
- ❑ Rent receipt
- ❑ Tenant Agreement

Thomas O. Forslund, Director

Governor Matthew H. Mead

State of Wyoming
Department of Health

NOTICE OF PRIVACY PRACTICES

Original Implementation Date: April 14, 2003
Revision Effective Date: July 1, 2013

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.

This notice is available in alternate formats that meet guidelines for the Americans with Disabilities Act (ADA). To request an alternate format, contact the Wyoming Department of Health (WDH) by telephone at (307) 777-7656, by teletype at (307) 777-5648, or by facsimile at (307) 777-7439.

The WDH provides many types of health-related services, programs (e.g., children's special health), and plans (e.g., Medicaid) which require collection or creation of sensitive client information, also known as protected health information (PHI). WDH is required by both state and federal law to maintain the privacy of its clients' PHI, to provide notice of its legal duties and privacy practices with respect to PHI to its clients, and to notify affected individuals following a breach of unsecured PHI.

This notice of privacy practices (NoPP) describes how WDH may use or disclose your PHI. WDH is required to follow the terms of its most current NoPP. WDH may change its NoPP. A copy of the new NoPP will be posted at all WDH facilities and on the WDH website as required by law. Changes to the NoPP may apply to both your existing and future PHI and records. You can obtain a copy of the current NoPP from any WDH facility or on-line at www.health.wyo.gov.

Use and Disclosures Without Your Authorization

- **For treatment**. WDH may use or disclose PHI to health care providers who are involved in your health care. For example, PHI may be shared to create and carry out a plan for your treatment.

- **For payment**. WDH may use or disclose PHI to receive payment or to pay for the health care services you receive. For example, WDH may provide PHI to bill your health plan for health care provided to you.

- **For health care operations**. WDH may use or disclose PHI to manage its programs and activities. For example, WDH may use PHI to review the quality of the services you receive.

- **For underwriting purposes.** WDH, in its capacity as a health plan, may use or disclose PHI for underwriting purposes. However, WDH may not use PHI that is genetic information for such purposes.

- **For appointments and informative purposes**. WDH may send you reminders for medical care or checkups. WDH may send you information about health services that may be of interest to you.

- **For public health activities**. WDH may use or disclose PHI to maintain vital records and track some diseases as required by law.

- **For health oversight activities**. WDH, in its capacity as a health oversight agency, may use or disclose PHI to inspect or investigate health care providers. WDH may disclose PHI to another health oversight agency for oversight activities authorized by law (e.g., to a health oversight agency conducting an audit of WDH).

- **As required by law and for law enforcement**. WDH may disclose PHI when required by law or court order, or pursuant to law enforcement investigations.

- **For government programs**. WDH may disclose PHI to other government programs that manage eligibility for public benefits/assistance.

- **To avoid harm**. WDH may disclose PHI to law enforcement to avert a serious threat to the health and safety of a person or the public.

- **For research**. WDH may use PHI to conduct studies and develop reports. However, these reports do not identify specific people.

- **To family, friends, and others**. WDH may disclose PHI to your family or other persons involved in your medical care.

Uses and Disclosures That Require Your Written Authorization

- **For situations not previously listed**. WDH will ask for your written authorization before using or disclosing your PHI. You may revoke this authorization in writing at any time. WDH cannot take back any uses or disclosures already made with your authorization.

- **Uses and disclosures which specifically require your authorization.** Except in limited circumstances, WDH must obtain your written authorization prior to any uses or

disclosures of psychotherapy notes, of PHI for marketing purposes, or of PHI for the sale of that PHI. For marketing or sale of PHI, the authorization must inform you if WDH will receive direct or indirect payment from a third party.

- **Other laws protect PHI.** Many WDH programs are subject to additional laws regarding the use and disclosure of your health information. For example, you must give written authorization for WDH to use and disclose your mental health and chemical dependency treatment records.

Your PHI Privacy Rights

- **Right to see and get copies of your records**. In most cases, you have the right to look at or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

- **Right to request to correct or update your records**. If you feel your records are inaccurate, you may ask WDH to change or add missing information. You must make the request in writing, and provide a reason for your request. WDH is not required to agree to the request.

- **Right to get a list of disclosures**. You have the right to ask WDH for a list of disclosures of your PHI made within the last six (6) years. You must make the request in writing.

- **Right to request restrictions on uses or disclosures of your PHI**. You have the right to ask WDH to restrict how your PHI is used or disclosed. You must make the request in writing and tell WDH what PHI you want to restrict and to whom you want the restriction to apply. WDH is generally not required to agree to a requested restriction. However, WDH must agree to your request to restrict uses and disclosures of PHI to a health plan (e.g., health insurance company) when you or someone other than the health plan has paid WDH for a health care item or service, unless the use or disclosure is required by law. Once a restriction is implemented, you can request either verbally or in writing that the restriction be terminated.

- **Right to revoke permission**. If you are asked to sign an authorization to use or disclose your PHI, you may cancel the authorization at any time. You must make the request in writing. This will not affect PHI already shared by WDH.

- **Right to choose how we communicate with you**. You have the right to ask WDH to share information with you in a certain way or in a certain place. For example, you may ask WDH to send information to your work address instead of your home address. You must make this request in writing. You do not need to explain the reason for your request.

- **Right to file a complaint**. You have the right to file a complaint if you do not agree with how WDH has used or disclosed your PHI.

- **Right to get a paper copy of this notice**. You have the right to ask for a paper copy of this notice at any time.

How to Contact WDH to Review, Correct, or Restrict Your PHI

You may contact your local WDH program office to:

- ✓ Ask to look at or copy your records.
- ✓ Ask to correct or change your records.
- ✓ Ask to restrict uses or disclosures of your PHI.
- ✓ Ask for a list of the times WDH disclosed your PHI.
- ✓ Ask to revoke your authorization to disclose PHI.
- ✓ File a complaint.

WDH may deny your request to look at, copy or change your records. If WDH denies your request, WDH will send you a letter explaining why your request is being denied and how to ask for a review of the denial. You will also receive information about how to file a complaint with WDH or with the U.S. Department of Health and Human Services.

How to File a Complaint or Report a Problem

You may contact any of the people listed below if you want to file a complaint or report a problem with how WDH has used or disclosed your PHI. Your benefits will not be affected by any complaints you make. WDH cannot retaliate against you for filing a complaint, cooperating in an investigation, or refusing to agree to something you believe is unlawful.

For More Information

If you have any questions about this notice or need more information, please contact the WDH Privacy/Compliance Officer.

De Anna Greene, CIPP/US, CIPP/G, CIPP/IT
WDH Privacy/Compliance Officer
Wyoming Department of Health
401 Hathaway Building
Cheyenne, WY 82002
Phone: (307) 777-8664
Fax : (307) 777-7439
E-mail: deanna.greene@wyo.gov

Region VIII - Office for Civil Rights
U.S. Department of Health and Human Services
999 18th Street, Suite 417
Denver, CO 80202
Voice Phone (800) 368-1019
FAX (303) 844-2025
TDD (800) 537-7697

State of Wyoming
Department of Health

Acknowledgement of Receipt
of Notice of Privacy Practices

PLEASE REVIEW CAREFULLY

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.

I, _____ ***(client's name),*** have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

_____ _____
Client's Signature Date

_____ _____
Client's Legal or Personal Representative Relationship

For Office Use Only:
Please have this document completed and signed by the individual receiving the Notice of Privacy Practices. Provide one copy to the individual; file the original in their case record.

- ☐ Completed form received by: _____
- ☐ Acknowledgement refused

  Efforts to obtain acknowledgment: _____
  _____
  _____

  Reasons why not obtained: _____
  _____
  _____