Wyoming Department of Health
Wyoming Medication Donation Program

Contents of Application

Page 1: Demographic information

a. If your physical address is different than your mailing address, please specify by filling out both sections for address.

b. All medications will be mailed to the mailing address (if different from the physical address) unless otherwise specified.

Page 2: Insurance and Income Information

- Specify the number of adults and children in your household
- If you and/or your spouse have additional sources of income, please specify those sources

Page 3: Prescription information

a. Include pharmacy information (so that we may transfer the prescription to us)

b. Include doctor information (so that we may contact the doctor for new prescriptions or questions about your medications)

Page 4: Instructions for Proofs of Income and Residency

Page 5: Statement Regarding No Income

Page 6: Residency Verification

Pages 7-8: Notice of Privacy Practices

a. Information for you about how your medical information will be handled by the Wyoming Medication Donation Program

b. Only page 7 needs to be signed and returned to us (page 8 can be retained by you for your records)

How to Submit Your Application and Documents:

Fax: (307) 635 - 2156
•••OR•••
Email: wdh-rxdonationinfo@wyo.gov
•••OR•••
Mail: Wyoming Medication Donation Program
2300 Capitol Avenue
Hathaway Bldg., Suite B27
Cheyenne, WY 82002

*****Only return pages 1, 2, 3, 5 (if applicable), 6 (if applicable), and 7 *****

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 7-10 days 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
2300 Capitol Avenue
Hathaway Bldg., Suite B27
Cheyenne, WY 82002
Phone:307-635-1297
Toll Free: 1-855-257-5041
Fax: 307-635-2156
www.wyomedicationdonation.org

Agency Use Only

Start Date: ____/____/____

End Date: ____/____/____

Initials:_____

Today's Date:	Last Name:	First Name:	Middle Name:

Date of Birth: / /	Gender: ☐ Male ☐ Female	Other names (ex: maiden name, nickname, etc.):

Mailing Address:

City:	State:	Zip Code:

Physical Address (if different from mailing address)

City:	State:	Zip Code:

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

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list out your allergies:

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

Marital status (check one): ☐ Married ☐ Single ☐ Separated

Release Form – Acknowledgement of Donation

- *My signature indicates that all of the information I have provided is true and correct. I understand that my eligibility will be valid for one year and that I will need to reapply each year to continue receiving benefits of this program.*
- *I attest that the information I have provided for insurance status and income is current and accurate. I understand that I may be asked to provide additional documentation related to insurance status and/or income as needed at any time to determine eligibility or continue eligibility. I will notify staff of any changes to employment, income, insurance status, or contact information prior to having additional prescriptions filled.*
- *I attest that I am a permanent resident of the State of Wyoming. I understand that I may be asked to provide additional documentation related to residency as needed to determine eligibility.*
- *I hereby grant permission to this agency to obtain and share the information I have provided for the purposes of determining eligibility for medication assistance. I understand that the Wyoming Medication Donation Program staff determines my eligibility at their discretion and my eligibility status is at-will.*
- *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

Signature of Applicant: _____Date: _____

**** In order to be approved for the Wyoming Medication Donation Program, your signature is required ****

Insurance and Income Information

**** Please Fill Out All Portions ****

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

Private Insurance (prescription)	☐ Yes ☐ No	ID#:	Company:
Medicare Part A/B	☐ Yes ☐ No	ID#:	Company:
Medicare Part D	☐ Yes ☐ No	ID#:	Company:
Medicaid (any state)	☐ Yes ☐ No	ID#:	Company:

If yes to any of the above, why are you applying to WMPD?

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

Employment Status (check one):

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

Income Detail:

(if married, please list spouse income)

I hereby attest that my current estimated annual income from wages is: $ _____

Spouse's annual income (if applicable): $ _____

Additional sources of income (such as social security disability income (SSDI), worker's compensation benefits, dividends, interest, assistance from family/friends/charity, public assistance and/or food stamps, or other sources: $ _____

Spouse's additional income (if applicable): $ _____

If you and/or your spouse have other sources of income, please specify those here: _____

Income for *all others* living in my household during the same 12-month period: $ _____

Number of individuals in household (including you and spouse): _____

Total income from wages and all other sources of income: $ _____

*****Proof of income for you and your spouse (if applicable) must be submitted. See Page 4 for details*****

Wyoming Department of Health

Wyoming Medication Donation Program

Don't let unused medicine go to waste!

Prescription Information

Primary Doctor's Name:

Phone number: ( ) -	Fax number: ( ) -

Do you see more than one doctor? ☐ Yes ☐ No

Medication Name and Strength: (list *all* medications you take)	**Directions for use:**	**Doctor:** (please specify)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pharmacy Information:

If you have used another pharmacy in your local area, please fill out the information below:

Name of current/most recently used pharmacy: _____

Pharamcy Phone Number: ( ) -

Rx Number or Drug name(s) (separate each with a comma):

_____

Instructions for Proofs of Income and Residency

Proof of Income:

a) Include a copy one of the following: paystubs (at least 1 months' worth), child support payments, disability/social security payments, unemployment payments, retirement payouts, workers compensation benefits, dividends, royalties, interest payments, public assistance and/or food stamps, etc.

b) All documents reflecting income shall include your name and/or address, date, and payment frequency/date ranges (to verify that the income belongs to the applicant and that the income is current).

c) Income will be dependent on marital status:

   a. If you are single, only provide proof of your income

   b. If you are married, you must provide proof of your income and your spouse's income

d) Documents should be dated within the last 3 months

e) If you currently have no source of income, please fill out the "Statement Regarding No Income" form (page 5).

   a. List sources of income (food, housing, transportation). Sources could be friends/family, taking the bus/walking, SNAP benefits for food, savings, etc. You cannot leave sources blank or list "self"

Proof of Residency:

a) Include a copy of one of the following: a utility bill, rent receipt, or tenant (lease) agreement
   a. Preferred utility bills would be an electric, water/trash/sewer, or gas bill
   b. Rent receipts must include your name, address, date, signature, and payment amount.
   c. Tenant (lease) agreements must include your name, address, date, signature, and lease term dates

b) Documents should be dated within the last 3 months

c) Photocopies of driver's licenses are not acceptable

d) If you currently do not pay rent and/or utilities at your residence and live with someone else (or are in a shelter/facility), please fill out the "Residency Verification" form (page 6).

   a. If you live with someone else (i.e. their name is on the utility bills and/or lease), then have the person you live with sign the form. No additional documents are needed.

   b. If you live in a shelter/facility, then a facility direction shall sign the form. No additional documents are needed.

Wyoming Department of Health
Wyoming Medication Donation Program

Statement Regarding No Income

Only use this form if you do not receive ANY income

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

I, _____, am currently unemployed.
(Please print your first and last name)

*By signing this form I attest that I **do not** have any income from any origin (i.e. child support, social security, VA benefits, unemployment benefits, workmen's compensation, disability, tax return, pay stubs, retirement/pension payments, other Investments, etc.). If married, your spouse's income will need to be provided, in addition to you (patient) signing this form attesting to no income.*

I have funds available to cover my expenses from the following sources:

My **HOUSING** expenses are covered by _____

My **FOOD** expenses are covered by _____

I certify that all of the above information is true and accurate. I understand that this information is used to determine eligibility for the program. I will notify the program of any changes in employment, income, or insurance status prior to having additional prescriptions filled.

_____ _____
Patient Signature Date

Rev. 03/01/24

Wyoming Department of Health
Wyoming Medication Donation Program

Residency Verification

Only use this form if you do NOT pay rent and/or utilities at your residence

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

I, _____, am currently staying with:
(Person applying for program)

☐ A friend, family, or roommate who pays rent/utilities.

_____
(Please print name of family, friend, roommate, etc. whom you are staying with)

☐ In a Shelter, Treatment Facility, or other Residential Facility.

_____
(Please print name of Shelter/Treatment Facility, etc.)

At this Address:

_____
(Street Address)

_____
(City, State, & Zip Code)

_____ _____
Signature of person applying for program Date

_____ _____
Signature of family, friend, roommate, or shelter/treatment facility Director Date

By signing above, I attest that the person applying for medication assistance from the Wyoming Medication Donation Program is residing at the address listed above as of the date signed.

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: _____

_____

_____

WYOMING DEPARTMENT OF HEALTH

Notice of Privacy Practices

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.

YOUR RIGHTS

When it comes to your protected health information, you have certain rights.

Get an electronic or paper copy of your protected health information -- You must make the request in writing. Ask us how to do this.

Ask us to correct your protected health information -- You must make the request in writing. Ask us how to do this.

Request confidential communications -- You can ask us to contact you in a specific way, for example, home or office phone, or to send mail to different address. You must make this request in writing.

Ask us to limit what we use or share -- You can ask us **not** to use or share certain protected health information for treatment, payment, or our operations.

Get a list of those with whom we've shared information -- You can ask for a list (accounting) of the times we've shared your protected health information for six years prior to the date you ask, who we shared it with, and why. You must make the request in writing. Ask us how to do this and about reasonable, cost-based fees depending on the frequency you ask for the list.

Get a copy of this privacy notice -- We will promptly provide you with a paper copy.

Choose someone to act for you -- If you have given someone medical power of attorney or if you have a legal guardian, that person can exercise your rights and make choices about your protected health information. We will make sure the person has this authority and can act for you before we take any action.

OUR REPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised your privacy or security.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

YOUR CHOICES

For certain protected health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care or payment for care. Share information in a disaster relief situation. Include your information in a hospital directory. Contact you for fundraising efforts --We may contact you for fundraising efforts, but you can tell us not to contact you again. *If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious and imminent threat to health and safety.*
In these cases, we never share your information unless you give us written permission:	• Marketing purposes; Sale of your information; Most sharing of psychotherapy notes

OUR USES & DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Manage treatment you receive	We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis so we can arrange additional services.*
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether you qualify for Medicaid, CHIP, or other government health programs.	***Example:*** *We use protected health information about you to manage your treatment and services and develop better services for you.*
Bill for your services	We can use and share your protected health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan, so it will pay for your services.*
Pay for your health services	We can use and disclose your protected health information as we pay for your health services.	***Example:*** *We share information about you with your health plan to coordinate payment for your services.*
Administer your plan	We may disclose your protected health information for health plan (government health programs) administration.	***Example:*** *We may share information about you with our contracted health plans to better manage your plan.*

How else can we use or share your health information?

Help with public health and safety issues	We can share protected health information about you in situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect • Reducing a serious threat to anyone's health or safety
Do research	We can use or share protected health information for health research.
Comply with the law	We will share protected health information about you if state or federal laws require it.
Respond to organ donation requests	We can share protected health information about you with organ and tissue procurement organizations.
Work with a medical examiner or funeral director	We can share protected health information with a coroner, medical examiner, or funeral director when an individual dies.
Address worker' compensation, law enforcement, and other government requests	We can use or share protected health information about you: • For workers' compensation claims • For law enforcement purposes • With health oversight agencies authorized by law • For special government functions
Respond to lawsuits and legal actions	We can share protected health information about you in response to a court or administrative order, or subpoena.

File a complaint if you feel your rights are violated:

This notice is administered by the Wyoming Department of Health, Office of Privacy, Security, and Contracts (OPSC). You can complain to the WDH, Office of Privacy, Security, and Contracts if you feel we have violated your rights by sending a letter to 401 Hathaway Building, Cheyenne, WY 82002; calling (307) 777-7656; or emailing WDH-HIPAA@wyo.gov. Our privacy contact or a program specialist will work to respond to you as soon as we are able.

You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

We will not retaliate against you for filing a complaint.

Wyoming Department of Health

More stringent laws

Please be aware that these more stringent protections apply to us for specific components at specific times. We will ensure to apply these more stringent protections to your protected health information, as relevant.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our offices, and on our website at https://health.wyo.gov/admin/privacy/.

Your Information. Your Rights. Our Responsibilities.

Effective Date: September 2023