Dear WVRx Applicant:

Attached are your enrollment forms for WVRx.

Please do not forget to include the name, address, and phone number of each prescriber.
Please use the back of the application page or separate sheet if necessary.

This is what we need you send us for a faster eligibility decision:

- **Assemble proof of your entire household income (ANYONE LIVING UNDER YOUR ROOF) and be sure to enclose this information along with the WVRx Checklist, Enrollment Form and a current Medicaid denial.**
- We **MUST** have a CURRENT 1040, 1040A tax return, W-2, or 1099 for **EVERY** household member over the age of 18. **NOTE:** If you or your family members do not file income taxes, then we **MUST** have a filled out Form 4506-T which is attached. If you do not file taxes, and are on social security, we must have a 1099 and your Benefits Statement for the CURRENT year.

- Send $30 by check or money order. This fee is refunded to you if you are not eligible. (This is to help offset the cost of shipping the medications.)

- WVRx will mail both you and your doctor(s) a letter of eligibility determination once we verify your information.

- **Tell your doctor/prescriber** that you use the WVRx Charitable Mail Order Pharmacy to obtain your medication.

- **OR—You may mail your prescriptions to us at the address below**.

- **OR—You may have your doctor fax them to the WVRx pharmacy at: 1-304-414-2200**.

- **OR—Your doctor may E-Prescribe too**! **SEND E-Prescriptions to "WV HEALTH RIGHT"**

- Once filled, your prescription(s) will be mailed to you. We cover only the State of West Virginia.

- NOTE: WVRx is unable to mail prescriptions to P.O. Boxes.

NOTE: If you only have a P.O. Box, please provide your physical address along with your PO Box.

The address to mail ALL eligibility documents and prescriptions is:

WVRx Patient Eligibility
1520 Washington Street East
Charleston, WV 25311

- **The WVRx staff is available to answer any questions via a toll free number at 1-877-388-9879. If you reach a voicemail, PLEASE leave your name and phone number! All calls are returned!**
- **Patients must reapply each year for WVRx services; Patient eligibility is determined annually.**

- **IMPORTANT: THE WVRx DRUG LIST DOES NOT COVER CONTROLLED DRUGS/NARCOTICS.**
- **IMPORTANT: WVRx DOES NOT FILL MEDICATIONS THAT ARE AVAILABLE AS GENERICS**

- **IN ADDITION: If your medications are not available directly through WVRx, we may be able to fill out individual patient assistance forms on your behalf depending on the medications availability.**

If you have any further questions, please call us at 877-388-9879 OR email us at wvrxinfo@wvrx.org . You may also visit our website at: www.wvrx.org for more information.

Caring for West Virginians,
The WVRx Team

REVISED: 03.04.2014

WVRx Patient Checklist

MAIL TO: **West Virginia Rx—Patient Eligibility**
1520 Washington Street East
Charleston, WV 25311

CHECK ALL THAT APPLY:

- ☐ 1. **I HAVE NO HEALTH INSURANCE OR PRESCRIPTION DRUG COVERAGE**
- ☐ 2. **I HAVE HEALTH INSURANCE BUT NO PRESCRIPTION DRUG COVERAGE**
- ☐ 3. **I RECEIVE NO GOVERMENT ASSISTANCE (MEDICAID, MEDIACRE PATR D, VETERANS BENEFITS, ETC.)**
- ☐ 4. **I AM A WEST VIRGINIA RESIDENT**
- ☐ 5. **I HAVE ENCLOSED THE ELIGIBILITY FORM, SIGNED AND DATED IT.**

PLEASE PLACE A CHECK MARK BESIDE THE NUMBER OF PEOPLE WHO LIVE IN YOUR HOME

2015 WVRx Income Guidelines			
	# People Living in Your House	**250% of FPL Annually**	**Monthly Income**
	1	$29,175/yr or less	$2,431.00 or less
	2	$39,325/yr or less	$3,277.00 or less
	3	$49,475/yr or less	$4,123.00 or less
	4	$59,625/yr or less	$4,969.00 or less
	5	$69,775/yr or less	$5,815.00 or less
	6	$79,925/yr or less	$6,660.00 or less
	7	$90,075/yr or less	$7,506.00 or less
	8	$100,225/yr or less	$8,352.00 or less
For families with more than 8 persons, add $8,040 for each additional person.			

I have ENCLOSED THE FOLLOWING PROOF OF INCOME—CHECK ALL THAT APPLY:

- ☐ **1. TAX RETURN ENCLOSED FOR CURRENT YEAR** (Fastest way to process your application)
- ☐ **2. 1099 BENEFITS STATEMENT ENCLOSED FOR CURRENT YEAR**
- ☐ **3. CURRENT W-2 from Employer**
- ☐ **4. 4506-T FORM** (Proof of Non-Filing or Authorization for WVRx to obtain your tax return, see attached)

NOTE: If you do NOT file income taxes, we ***MUST*** have Form 4506-T (Proof of Non-Filing, form included)

NOTE: We MUST have Proof of Income for every member of your household over the age of 18.

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CHECK ALL THAT APPLY:

- ☐ 1. MEDICAID DENIAL LETTER (WVRx **MUST** receive this in order to approve your application)
- ☐ 2. I HAVE ENCLOSED THE $30 ANNUAL PROCESSING FEE (CHECK OR MONEY ORDER)

NOTE*: *If ineligible, your fee will be returned promptly. There is no fee for medication through WVRx.

NAME OF APPLICANT: _____

PHONE NUMBER OF WHERE APPLICANT CAN BE REACHED: _____

FORM REVISED: 03.04.2014

West Virginia Rx Enrollment: ☐ New ☐ Re-enrollment

What County do you live in?

Your LAST Name:	**Your First Name:**	**M.I.**	**Date of Birth** / /	**Age**	**Marital status (check one)** ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other

Social Security Number	**MAIN Phone Number**	**Other Numbers (cell,work)**	**Name & Phone # of someone you authorize to speak on your behalf**

STREET/SHIPPING ADDRESS (If PO Box, please list physical address)

ADDRESS

CITY **STATE** **ZIP CODE**

Gender
☐ Male ☐ Female

Ethnicity:
☐ Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Hispanic ☐ Other

Household Status
☐ Homeless ☐ Own Home ☐ Living with friend, relative, parent, etc. ☐ Shelter ☐ Rent

PLEASE TELL US YOUR INSURANCE STATUS
(Check ALL that apply)

☐ Uninsured ☐ Medicaid ☐ Medicare ☐ Medicare Part D
☐ Veterans Drug Program ☐ State Prescription Program
☐ Health Insurance **AND** Prescription Drug Coverage
☐ Health Insurance but **NO** Prescription Drug Coverage
☐ Other_____
Medicare ID No. and Effective Date_____

Are you Disabled? Yes ☐ No ☐
Are you a Veteran: Yes ☐ No ☐

Are you a U.S. Citizen: Yes ☐ No ☐
If not, are you:
A Resident Alien: Yes ☐ No ☐

Green Card No._____

Have you ever applied for free medicine before from any drug company?
☐ **NO** ☐ **YES** **If yes, which ones?**

IMPORTANT: PLEASE LIST YOUR DOCTOR(S)

Main Doctor's Name:

Address:

City, State, ZIP:

Phone Number:

FAX Number:

Other Doctor's? Please use back of form for additional Doctor(s) Info!

IMPORTANT! INFORMATION WVRx NEEDS:

Do you have any drug allergies? ☐ NO ☐ YES **(If Yes, PLEASE LIST)**

Have you been hospitalized in the past year? ❑NO ❑YES

# of times?_____ Hospital Name(s) _____

Have you been to an emergency room in the past year? ❑NO ❑YES

# of times? _____ Hospital Name (s)_____

ANNUAL HOUSEHOLD INCOME INFORMATION *(THE TOTAL AMOUNT MONTHLY X 12 FOR EVERY PERSON LIVING AT YOUR ADDRESS)*

_____ **TOTAL NUMBER OF PEOPLE LIVING IN YOUR HOUSEHOLD?** _____**HOW MANY ARE UNDER 18?**

$_____ **TOTAL YEARLY INCOME FROM ALL HOUSEHOLD SOURCES**
ADD UP ALL Income & Wages: Monthly Pay, Social Security, Unemployment, Pension, Disability, Retirement, Worker's Comp., Other, etc.)

STATEMENT OF RELEASE & PATIENT SIGNATURE

I certify that the above information I have provided to WVRx for prescription assistance is true and accurate to the best of my knowledge and belief and that I have made no false or misleading statements.
I understand that WVRx may need to disclose personal and medical information necessary to determine eligibility for available drug manufacturer programs and to secure my prescribed medication. I agree to allow WVRx staff to communicate with both drug manufacturers and my health care providers regarding medication assistance.
I give permission to verify my participation in Social Security, Medicare, Medicaid or Veterans Administration, Private Insurance and/or anywhere I have reported that I receive income.
I agree to immediately notify WVRx of any changes to my uninsured status for prescription drugs, including but not limited to enrollment in Medicaid & Medicare programs, or if my financial situation changes.
I agree to allow pharmaceutical company auditors to review my information as needed for their program requirements.
I give permission to WVRx or its representatives to complete patient assistance program applications on my behalf in the event of my absence and for the purpose of expediting my prescription assistance. This consent is valid as long as I am an eligible and approved patient of WVRx or until I revoke my permission in writing.

By my signature, I authorize the release of medical information about me to WVRx staff and to communicate with health care providers for the purposes of eligibility and benefits associated with West Virginia Rx.

PATIENT SIGNATURE:_____ **DATE:**_____

If you work, who is your Employer? _____

Form **4506T-EZ**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Short Form Request for Individual Tax Return Transcript

▶ **Request may not be processed if the form is incomplete or illegible.**

OMB No. 1545-2154

Tip. Use Form 4506T-EZ to order a 1040 series tax return transcript free of charge, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number or individual taxpayer identification number on tax return**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 If the transcript is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

Third party name	Telephone number
West Virginia Rx	877-388-9879 or 304-414-5935

Address (including apt., room, or suite no.), city, state, and ZIP code

1520 Washington Street East, Charleston WV 25311

Caution. If the tax transcript is being mailed to a third party, ensure that you have filled in line 6 before signing. Sign and date the form once you have filled in this line. Completing this step helps to protect your privacy. Once the IRS discloses your IRS transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.

6 **Year(s) requested.** Enter the year(s) of the return transcript you are requesting (for example, "2008"). Most requests will be processed within 10 business days.

2013 | 2014 | | |

☐ Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return.

Note. *If the IRS is unable to locate a return that matches the taxpayer identity information provided above, or if IRS records indicate that the return has not been filed, the IRS may notify you or the third party that it was unable to locate a return, or that a return was not filed, whichever is applicable.*

Caution. Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am the taxpayer whose name is shown on either line 1a or 2a. If the request applies to a joint return, **either** husband or wife must sign. **Note.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

Sign Here	**Signature** (see instructions)	Date	Phone number of taxpayer on line 1a or 2a
	Spouse's signature	Date	