

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 and Enrollment Form**
- 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 available from the IRS or through WVRx. 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. If you cannot afford the fee, waivers are available on a case-by-case basis. Please see the Patient Checklist for Fee Waiver Instructions.
- 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 at no cost. We cover only the State of West Virginia.
- NOTE: WVRx is unable to mail prescriptions to P.O. Boxes. Please include your Rural Route with your Box number.

**NOTE:** If you only have a P.O. Box, we can mail your medication to an alternate address with the proper documentation. Please let us know on your Enrollment Form if you only have P.O. Box delivery.

**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 (Some exceptions apply if you are a patient of Welch Community Hospital Outpatient Clinic).**
- **IN ADDITION: PLEASE LOOK TO SEE IF YOUR MEDICATION IS ON THE WVRx LIST. If it is not, we are able to fill out individual patient assistance forms on your behalf.**

If you have any further questions, please call us at 877-388-9879 OR email us at [wvrinfo@wvr.org](mailto:wvrinfo@wvr.org) . You may also visit our website at: [www.wvr.org](http://www.wvr.org) for more information.

**Caring for West Virginians,  
The WVRx Team**

REVISED: 8.14.2013

# 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 GOVERNMENT ASSISTANCE (MEDICAID, MEDICARE PART D, VETERANS BENEFITS, ETC.)
- 4. I AM A WEST VIRGINIA RESIDENT
- 5. I HAVE ENCLOSED THE ELIGIBILITY FORM AND HAVE SIGNED AND DATED IT.

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

2013 WVRx Income Guidelines		
# People Living in Your House	200% of FPL Annually	Monthly Income
<input type="checkbox"/>	1	\$22,980/yr or less
<input type="checkbox"/>	2	\$31,020/yr or less
<input type="checkbox"/>	3	\$39,060/yr or less
<input type="checkbox"/>	4	\$47,100/yr or less
<input type="checkbox"/>	5	\$54,140/yr or less
<input type="checkbox"/>	6	\$63,180/yr or less
<input type="checkbox"/>	7	\$71,220/yr or less
<input type="checkbox"/>	8	\$79,260/yr 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)

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

You may request this form from WVRx **OR** you can get it from the IRS.

**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: (WVRx may waive your fee if you include #1 and #2 below)**

- 1. MEDICAID DENIAL LETTER (WVRx **MUST** receive this to waive your \$30 fee)
- 2. SNAP Benefits Letter (WVRx **MUST** receive this to waive your \$30 fee)
- 3. UNEMPLOYMENT DOCUMENTATION (Copy of Unemployment Letter, Layoff, Termination, etc.)
- 4. WORKER'S COMPENSATION LETTER OR LETTER/PROOF OF DETERMINATION (Worker's Comp will provide a "Verification of Benefits" statement to you)
- 5. 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:** \_\_\_\_\_

# West Virginia Rx Enrollment:

New

Re-enrollment

What County do you live in?

<b>Your <u>LAST</u> Name:</b>	<b>Your <u>First</u> Name:</b>	<b>M.I.</b>	<b><u>Date of Birth</u></b> / /	<b>Age</b>	<b>Marital status (check one)</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other
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<b><u>Social Security Number</u></b>	<b><u>MAIN Phone Number</u></b> ( )	<b><u>Other Numbers (cell,work)</u></b> ( ) ( )	<b><u>Name &amp; Phone # of someone you authorize to speak on your behalf</u></b>
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***STREET/SHIPPING ADDRESS (IMPORTANT! WVRx CANNOT SHIP TO P.O. BOXES!)***

**ADDRESS**

**CITY STATE ZIP CODE**

<b><u>Gender</u></b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b><u>Ethnicity:</u></b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other
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**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)**

**IMPORTANT! INFORMATION WVRx NEEDS:**

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!

**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?** \_\_\_\_\_

# Short Form Request for Individual Tax Return Transcript

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

**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](http://IRS.gov) and click on "Order a Transcript" or call 1-800-908-9946.

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

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

**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.

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.

Phone number of taxpayer on line 1a or 2a

**Sign Here** ▶ \_\_\_\_\_  
Signature (see instructions) Date

▶ \_\_\_\_\_  
Spouse's signature Date