



United Way -
Thomas Jefferson Area

MEDICATION ASSISTANCE CONTRACT

In signing this contract, I agree to the following:

1. I agree that I will immediately inform my RxRelief Caseworker, prescriber and/or United Way - Thomas Jefferson Area should my insurance status change.
2. I agree to promptly provide proof of income upon request and will update this documentation annually.
3. I understand that there may be delays in getting my medicine, as it may take 4 to 8 weeks for my medication to arrive from the manufacturer.
4. I agree to promptly notify my RxRelief Caseworker, prescriber and/or United Way - Thomas Jefferson Area upon any changes in my income or the income of those in the household, number of people in the household, address and/or phone number.
5. I agree to keep my appointments with my doctor/provider.
6. I understand that I need to contact my RxRelief Caseworker and/or prescriber to check the availability of my medication.
7. I understand that I need to contact my RxRelief Caseworker for refills.
8. I agree that I will not submit an insurance claim or other claim for payment to any third-party payer for any medications I receive from this program. I agree that any medications that I receive will be used only for my personal use. I agree not to resell, offer for trade, trade or barter, or return for credit any medications.
9. I understand that neither this program nor the agents of it are in any way guaranteeing or promising medication to me.
10. I authorize any agent of the program to discuss my medical condition(s) with my provider and to review my medical records to ensure appropriate documentation for the purpose of completing a prescription application.
11. My signature below authorizes the RxRelief Caseworker or other agent of the program to sign my name on the necessary forms needed to order my medication. I understand that doing so will expedite the ordering process.
12. I authorize the RxRelief Caseworker to obtain a copy of my federal tax return from the IRS to apply for medication(s), if necessary.
13. I understand that the signature authorization is valid until revoked.

Patient Signature

Date

Printed Patient Name

Social Security #

Please contact Helen Frye, RxRelief Caseworker at (434) 972-1709 with any questions or concerns regarding this contract.

Please fax to (434) 972-1719