ANNUAL PATIENT CERTIFICATION

beacon Rx
CHARITABLE PHARMACY

Appointment Scheduled
☐MC ☐AC ☐LC

Cert Date: _____

Time: _____

PATIENT INFORMATION

Last name _____ **First name** _____ **Date of Birth** _____

Address _____

Cell Phone _____ **Alt Phone** _____ **Gender** ☐ Male ☐ Female ☐ Undefined

☐ I give permission for personnel to communicate by **text messages,** including personal health information, on my cell phone listed above. ☐ **Enrolled**

☐ I give permission for personnel to leave **detailed voice messages,** including personal health information, on the phone listed above. ☐ **Cell** ☐ **Alt**

Social Security# _____ **Race/ Ethnicity** _____ **Language** _____
☐ Undocumented ☐ Non-citizen status

☐ **Recert** ☐**New- Referred by:** ☐PCP/Health Worker ☐Family/Friends ☐Free Clinic ☐Hospital ☐Social Services ☐SVDP ☐Media
☐Other: _____

PRE-CERTIFICATION - Check previous certification date.

Proof of Identification (only 1)

☐ Driver's License/State ID ☐ Passport ☐ Signed Attestation ☐Other: _____

Proof of Residency (only 1)

☐ Driver's License/State ID ☐ Utility/mortgage bill, bank statement, rent receipt, lease agreement, check or pay stubs (< 60 days old) ☐ County auditor website (if homeowner)

Medical Information

Prescription Insurance: 1. ☐ I have verified this patient does not have Ohio Medicaid. 2. ☐ Uninsured ☐ Medicare Part D ☐ Private

Prescription Transfer (new patients):

Pharmacy Name: _____ Phone: _____

Rx's Needed: _____

Power of Attorney: ☐ If caregiver is certifying, I have educated to bring medical POA papers.

Monthly Gross Household Income *(last 30 days from scheduled cert. date)*

Name	Amount	Source
1. _____	$ _____	_____
2. _____	$ _____	_____
3. _____	$ _____	_____

Total People in Household: _____ *(Regardless of income)* Est. Total GROSS Income: _____ Est. %FPL: _____ % *(If 301% or more, start Expense Report)*

Intake Signature: _____ **Date:** _____

☐ **Pharmacist Entry (if new)** ☐ **QS1 Scan** ☐ **Entered in Practice Fusion** ☐ **One Drive Scan**

CERTIFICATION -Copy required documentation.

☐ **Identification** ☐ **Ohio Residency** ☐ **Medical Information**

☐**Monthly Household Income** ☐ **Expense Report** (if FPL 301% or more)

Today's Date: _____ **Room#:** _____

Next CMR Date: _____ *(6 months from today)* **Cert Exp Date:** _____ *(1 year from today)*

FPL%: _____% **PAP Eligible?** ☐**Yes*** ☐**No**

*If Ohio resident, uninsured, 300% FPL or less

Monthly Household Income Summary

$_____ Source: _____

$_____ Source: _____

$_____ Source: _____

$_____ Source: _____

$_____ Source: _____

$_____ Source: _____

Total GROSS: $_____ __# People in Household: __ _

Attach conversion tool if NET *Regardless of income*

Attestations

☐ In the past 30 days, I was paid $_____ by cash or check, but I was not provided documentation to prove this income.

☐ No one in my household has income.

☐ I do not have a picture ID, but I verify my identity is correctly documented on this paperwork.

Other: _____

_____

_____

NAVIGATION - Document responses in QS/1 database.

HEALTHCARE ACCESS

Conflict Code: NP
CPT Code: new-99201 (recert- 9921l)
NOC(WH), ER-Y(N), HV-Y(N),
PCP-Y(N), (if new) referred by____(pg1)
Delete (#)

No Yes Have you been to an emergency room or urgent care in the past 6 months?

No Yes Have you been admitted to a hospital in the past 6 months?

No Yes Do you have a primary care doctor who can prescribe your medications?

MEDICAID ENROLLMENT

Conflict Code: PP
MEDICAID ELIGIBLE,
REFERRED or REFUSED

No Yes Are you a U.S. Citizen (or non-citizen status) with FPL <138%?
IF YES... educate to apply, refer to SVDP Insurance Navigator, and document in QS/1

☐ Referred ☐ Pt refused – Refusal reason: _____

FOOD SECURITY

Conflict Code: PP
FOOD INSECURE, PANTRY

No Yes In the past 30 days, did you worry your food would run out before you have money to buy more?
IF YES... educate about NOC Pantry and document in QS/1

☐ Referred

TRANSPORTATION

Conflict Code: PP
TRANSPORTATION

No Yes Do you delay or neglect going to the doctor or pharmacy because of distance or transportation?
IF YES...ask the next question.

No Yes Would bus passes help you get to your medical appointments?

Patient Signature: _____

Pharmacist Approval: _____

QS/1 ☐ QA ☐ ONEDRIVE ☐

Advocate Initials