

Patient Enrollment Application (2022-23)

Thank you for your interest in the MedAssist program. Please complete the enclosed application and return it to MedAssist along with the required documents.

Upon receipt of your completed application, MedAssist staff will determine if you are eligible for financial assistance based on our program guidelines and subject to available funding. Please understand that all approvals are based on available funding and are on a first-come-first-served basis.

Please send complete application packet to:

Fax: (408) 885-4093

Mail: Attn: MedAssist
777 Turner Dr, Suite 330
San Jose, CA 95128

Email: medassist@hhs.sccgov.org

Drop off: Any Santa Clara Valley Medical Center Outpatient Pharmacy

VALLEY HEALTH CENTER BASCOM

750 S. Bascom Avenue
San Jose, CA 95128
(408) 885-2320

VALLEY HEALTH CENTER GILROY

7475 Camino Arroyo
Gilroy, CA 95020
(408) 852-2212

**VALLEY HEALTH CENTER
MOORPARK**

2400 Moorpark Ave
San Jose, CA 95128
(408) 885-7675

**VALLEY HEALTH CENTER
DOWNTOWN**

777 E. Santa Clara Street
San Jose, CA 95112
(408) 977-4500

VALLEY HEALTH CENTER LENZEN

976 Lenzen Ave,
San Jose, CA 95126
(408) 792-5170

**VALLEY HEALTH CENTER
SUNNYVALE**

660 S. Fair Oaks Avenue
Sunnyvale, CA 94086
(408) 992-4830

**VALLEY HEALTH CENTER EAST
VALLEY**

1993 McKee Road
San Jose, CA 95116
(408) 254-6340

VALLEY HEALTH CENTER MILPITAS

143 North Main Street
Milpitas, CA 95035
(408) 957-0919

VALLEY HEALTH CENTER TULLY

500 Tully Road
San Jose, CA 95111
(408) 817-1360

VALLEY SPECIALTY CENTER

751 S. Bascom Ave
San Jose, CA 95128
(408) 885-2310

**O'CONNOR OUTPATIENT
PHARMACY**

2101 Forest Ave
San Jose, CA 95128
(408) 947-2988

Please contact us if you have any questions or need assistance filling out the application form.

Phone: (408) 970-2001

Email: medassist@hhs.sccgov.org

Hours: Monday – Friday, 9AM – 5PM

<https://scvmc.org/medassist>

Getting Started

What Information Do I Need?

1. Patient contact and demographic information
2. Prescription information
 - a. Medication name
 - b. Copy of prescription **OR** pharmacy information
3. Financial information
 - a. Estimate of annual gross household income and household size
 - b. Estimate of out-of-pocket healthcare expenses from previous calendar **(January 2021 – December 2021)**
 - c. Out-of-pocket healthcare expenses from previous calendar year **(January 2021 –December 2021)**. Out-of-pocket healthcare expenses include:
 - Medical and prescription co-payments
 - Insurance premiums

What Documents do I Need?

Proof of Residence in Santa Clara County – Provide **ONE** of the following:

- Current Rental Contract/Lease
- Current Mortgage Statement
- Current Utility Bill (Water, Electric, Gas, Garbage)
- Homeless (Completion of patient statement form)
- Vehicle Registration
- Driver License (Current)
- Letter of support from person with whom applicant is living with and proof of residency for that person

Proof of Identity (Photo ID Required) – Provide **ONE** of the following:

- Valid Driver's License
- Valid Passport
- Valid Government issued ID Card
- Valid Work or School ID Card
- Birth Certificate along with any valid photo identification

Proof of Income – Provide **ALL** that apply **for your entire household** for the period of **January 2021 - December 2021:**

- Recent **Tax Return (required)**
- Check Stubs (at least two (2))
- W-2 Form
- Award Letter (Social Security, Disability, Unemployment, Worker's Compensation)
- Cash Income Statements (including tips)
- Military Benefits Statement
- Rental Income Receipts

Proof of valid prescription(s) – Provide ONE of the following for each qualifying prescription:

- Copy of Prescription
- Pharmacy Contact Information

Section 1: Patient Information

Legal Last Name:*		Legal First Name:*		Legal Middle Name:	
Patient DOB (MM/DD/YYYY):*			Preferred Language:*		
Address:*					
City:*		State: CALIFORNIA		Zip Code:*	
Home Phone Number:*			Mobile Phone Number:		
Email Address:					
Gender Identity:*					
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male		<input type="checkbox"/> Non-binary <input type="checkbox"/> Other	
Ethnicity:*			Race:*		
<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Spaniard <input type="checkbox"/> Mexican <input type="checkbox"/> Central American <input type="checkbox"/> South American		<input type="checkbox"/> Latin American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Other Hispanic or Latino <input type="checkbox"/> Decline/Unable to specify		<input type="checkbox"/> Patient Declined / Unable to Specify <input type="checkbox"/> Asian, Filipino <input type="checkbox"/> Asian, Vietnamese <input type="checkbox"/> White, Arab <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian, Chinese <input type="checkbox"/> Asian, Laotian <input type="checkbox"/> Asian, Korean <input type="checkbox"/> Asian, Cambodian <input type="checkbox"/> Asian, Japanese <input type="checkbox"/> Asian, Indian <input type="checkbox"/> Asian, Pakistani <input type="checkbox"/> Black, African <input type="checkbox"/> Black, Other	
		<input type="checkbox"/> White, North American <input type="checkbox"/> White, European <input type="checkbox"/> White, Middle Eastern or North African <input type="checkbox"/> Black, African American <input type="checkbox"/> White, Other <input type="checkbox"/> Native American <input type="checkbox"/> Alaska Native <input type="checkbox"/> Asian, Other <input type="checkbox"/> Pacific Islander, Guamanian <input type="checkbox"/> Pacific Islander, Samoan <input type="checkbox"/> Pacific Islander, Hawaiian			
How Did You Hear About the MedAssist Program?*					
<input type="checkbox"/> Returning Applicant <input type="checkbox"/> Friend or Family <input type="checkbox"/> Financial Assistance Counselor <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Pharmacy: _____		<input type="checkbox"/> SCVMC Website <input type="checkbox"/> Instagram <input type="checkbox"/> Facebook <input type="checkbox"/> LinkedIn		<input type="checkbox"/> Newspaper <input type="checkbox"/> NextDoor <input type="checkbox"/> Other (please specify): _____	

Section 2: Prescription Information

Please list each of your current prescriptions from the following three (3) medication categories:

- Diabetes medication
- Asthma inhaler
- Epinephrine auto-injector

Prescription 1:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 2:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 3:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 4:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 5:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Prescription 6:		
Medication Name:*		
Medication Category: [select one]* Diabetes medication Asthma inhaler Epinephrine auto-injector		
<i>If you are not attaching a hardcopy prescription with this application, please fill out the section below:</i>		
Pharmacy Information:		
Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
City:	State:	Zip Code:

Section 3: Financial Information

Household Size	
Number of people in your household including yourself, your spouse or domestic partner and dependent children under age twenty-one (21), whether living at home or not.	
Income Information	
Total Annual Household Gross Income in the previous calendar year (January 2021 - December 2021) – <i>combined from all sources*</i>	
\$	
Annual Healthcare Expenses	
Household Healthcare Out-of-Pocket Expenses in the previous calendar year (January 2021 – December 2021) – <i>this includes your Medical and Prescription Co-payments, Insurance Premiums*</i>	
\$	



COUNTY OF SANTA CLARA
Health System

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1 Patient Name: _____
 Date of Birth: _____
 ID or Medical Record #: _____
 Address: _____

 Tel: _____

2 AUTHORIZATION: I give permission to _____ to use and release to
 Recipient Name: _____
 Address: _____
 Phone: _____ Fax: _____

3 PURPOSE: The health information disclosed may only be used for the following purpose(s): _____

4 INFORMATION TO BE RELEASED

A. **Medical Record**
 All health information (e.g. diagnosis, test results, treatment); OR
 Images and/or Films Reports Billing Dental

B. **HIV/AIDS Test Results** (A separate authorization is required for each disclosure.) **Initial:** ____

C. **Drug & Alcohol Treatment**(e.g. diagnosis, test results, treatment, billing, attendance) **Initial:** ____

D. **Mental Health** (e.g. diagnosis, test results, treatment, billing) **Initial:** ____

E. **Other** _____ **Initial:** ____

5 DELIVERY PREFERENCE:
 Mail Pick up Other _____

6 DELIVERY FORMAT:
 CD Film Paper Other _____

7 DURATION: This authorization is valid immediately and will be valid until _____ (give date).
 If I do not write in a date, it will expire twelve months from the date it was signed.

8 CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department, 751 S. Bascom Ave., San Jose, CA 95128 and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by CSCHS under this authorization or if the authorization was required for getting insurance coverage and the insurer has a legal right to contest a claim. Verbal cancellation will be accepted for behavioral health medical record pursuant to WIC Section 5328. Call: 408-885-5770.

9 CONDITIONS: I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on my giving or refusing to give this authorization except if my treatment is related to research, or if health care services are given to me only for creating protected health information for release to a third party. I also understand that I may refuse to sign this authorization.
 A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

10 REDISCLOSURE: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

11 _____ Patient/Patient's Representative Name _____ Patient/Patient's Representative Signature _____ Relationship _____ Date



NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge you have received a copy of our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** gives you information about how we may use and disclose your medical or protected health information (PHI). Please read it carefully.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, we will post the revised version in our facilities. You may obtain a copy of the latest ***Notice of Privacy Practices*** from our Registration or Admitting staff when you come to any of our facilities for services or treatment.

I hereby acknowledge receipt of the ***Notice of Privacy Practices*** of County of Santa Clara Health System (CSCHS).

Date: _____

Signature: _____
(patient/parent/conservator/guardian)

Name: _____
(please print)

=====

INABILITY TO OBTAIN ACKNOWLEDGEMENT

This portion must be completed only if no signature can be obtained. If it is not possible to obtain the individual's acknowledgement, describe good faith efforts made to obtain the acknowledgement, and the reasons why the acknowledgement could not be obtained.

Date: _____

Signature: _____
(Representative of CSCHS)

Title: _____

Terms and Conditions of Program Participation

1. Patient has applied, or has granted permission for a representative to apply on Patient’s behalf, to participate in the MedAssist program. If the patient meets eligibility criteria based on information provided in the application and funds are available, the Patient will be awarded a grant to assist with out-of-pocket healthcare expenses such as copayments, coinsurance, deductibles, and/or insurance premiums.
2. Patient understands that any false or information provided on the MedAssist application could lead to revocation of the Grant at any time and furthermore may constitute fraud for which the Patient may be legally liable.
3. If MedAssist becomes aware of any inaccurate information or fraudulent activity relating to the Patient’s application and the application is approved, participation in the program will terminate and MedAssist may recoup the amount of financial assistance provided to the Patient.
4. Patient authorizes SCVHHS to request a credit report and/or to verify any of the information provided in the application as deemed necessary.
5. MedAssist has the right at any time, without notice to Patient, to modify or discontinue all or any part of the MedAssist program and/or Grant.
6. Patient is not guaranteed or promised financial assistance, and that any assistance provided by MedAssist is limited to the terms and conditions established by MedAssist.
7. Patient agrees to notify MedAssist if any of the following information has changed:
 - a. Personal information: home address, phone number, E-mail address, contact information
 - b. Household information: had another child or adopted a child, child moves in or out of the home, death in the family, got married, getting divorced, legally separated, have a registered domestic partner
 - c. Job status: became unemployed, salary changed, got an extra job, spouse employment or salary changed
 - d. Income: income changes, investments or assets change, got an inheritance or pension, bought or sold property

- I have read and agree to fully comply with the Terms and Conditions of Program Participation. I understand that failing to do so may lead to termination of my participation in the MedAssist program.

I certify under penalty of perjury by my signature that the information I have provided as required in this agreement is true and complete to the best of my knowledge and belief.

Patient/Patient’s Representative Name

Patient/Patient’s Representative Signature

Relationship to Patient

Date