

## Welcome to MassMedLine

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Thank you for taking the time to call or visit our center, or attend one of our community programs. We understand that many people today have concerns about medications. It is our goal to provide you with a one-stop resource to assist in finding answers to your questions.

We at MassMedLine would like to work on your behalf to help you understand your medicines and to find help for you if you are having difficulties paying for your prescriptions. There are many options that can be explored.

### **To help us focus our efforts to your specific needs, please complete and return:**

- \* The enclosed MassMedLine Patient Profile Form.
- \* Any additional applications sent in this packet in the areas where highlighted.
- \* Please include income documentation; most recent Federal Income Tax return and/or most recent Social Security Benefits Award Statement and/or Pension Statement, W-2 and/or any other relevant income documentation.
- \* Please be sure to read, sign and date the privacy document on the back of the patient profile form. The additional copy is for you to keep.
- \* Please return to MassMedLine in the enclosed self-addressed envelope.

If additional household members are seeking assistance, contact our office toll free at (866) 633-1617 for an additional form.

Our staff of trained clinical pharmacists and case managers will explore all possible ways to reduce your costs while encouraging safe medication use and good health practices. We hope to work closely with you and your physician to ensure the best care.

MassMedLine  
Pharmacy Outreach Program

**What can MassMedLine assist you with?** \_\_\_\_\_  
\_\_\_\_\_

**Contact Information**

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Daytime Telephone number:** (\_\_\_\_) \_\_\_\_\_

**Date of birth** \_\_\_\_/\_\_\_\_/\_\_\_\_      **Social Security Number:** \_\_\_\_-\_\_\_\_-\_\_\_\_

**Sex:**  Male  Female      **U.S. Resident:**  Yes  No

**Number of dependents in household** (including self/spouse/children under 18) \_\_\_\_\_

**Marital Status:**  Single  Married  Divorced  Widowed  Separated

**Household Financial Information** (including self/spouse/children under 18)

**List all sources of yearly income (taxable and non-taxable) for you and your household.**

Social Security	\$	<input type="text"/>	Unemployment	\$	<input type="text"/>
Salary/Wages	\$	<input type="text"/>	Alimony/Child Support	\$	<input type="text"/>
Pensions/Annuities	\$	<input type="text"/>	Rental Income	\$	<input type="text"/>
Dividends/Interest	\$	<input type="text"/>	Other:	\$	<input type="text"/>
Disability/SSDI	\$	<input type="text"/>	<b>TOTAL INCOME:</b>	\$	<input type="text"/>

**Insurance Information**

**Are you currently enrolled in:**

Medicare (traditional)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	VA Benefits	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medicare Health Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prescription Advantage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medigap/Supplemental	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Private Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Medicaid/Mass Health	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Name of insurance carrier(s):** \_\_\_\_\_

**Do you have any Prescription Benefits?**  Yes  No

**Do you have any Prescription Discount Cards?**  Yes  No

If yes, what card(s)? \_\_\_\_\_

**Primary Care Physician Information**

Name \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**CONTINUE TO BACK OF FORM**

# MassMedLine Patient Profile

## Medication Information

Please list only your medications, please include over the counter medications, herbals and vitamins  
Any allergies to medications?  Yes  No -If yes, please list:

Medication	Dose	Frequency	Price you pay for med

Additional medications can be submitted on a separate sheet

## Patient Authorization

If you would like to authorize another person to talk with a MassMedLine representative on your behalf, please fill out the following information.

Person you authorize to speak with us: \_\_\_\_\_

This persons relationship to you: \_\_\_\_\_

Daytime phone number: (\_\_\_\_\_) \_\_\_\_\_

Your printed name: \_\_\_\_\_

Your signature: \_\_\_\_\_ Date \_\_\_\_\_

Authorization for Use or Disclosure of Health Information

*Please read carefully before signing this or any other document.*

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

I, \_\_\_\_\_, give authorization for employees of the Massachusetts College of Pharmacy and Health Sciences Pharmacy Outreach and Education Program (the "Program"), a division of the College's Health Education and Resource Center, to receive my personal health information and to act on my behalf as described below. I acknowledge receipt of the Program's Privacy Notice contained on the reverse side of this authorization form.

I authorize the employees of the Program to use and disclose my health information to address my medication and therapeutic needs, as well as my financial and social concerns, with my health care providers, insurers and legal guardians. I authorize the employees of the Program to use and disclose my health information to provide a comprehensive and professional assessment aimed at improving my overall health, monitoring proper medication use and compliance and procurement of free or discounted medications.

I understand that my health information will be kept confidential and will be disclosed only to those persons or parties acting to pursue cost-effective medications and to provide timely medications on my behalf.

I reserve the right to revoke this authorization in writing at any time by notice addressed to the Privacy Officer set forth below, except to the extent that action has been taken in reliance on this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

The name and address of the Privacy Officer is Dennis Lyons, 179 Longwood Avenue, Boston, MA 02115, Ph: (508) 373-0031, e-mail: [dennis.lyons@bos.mcphs.edu](mailto:dennis.lyons@bos.mcphs.edu)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Legal Guardian \*

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Legal Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

*\*For those 18 years of age or younger, a parent or legal guardian may provide an authorization signature. A legal guardian may also sign for someone with a physical or mental impairment that prevents an informed consent.*

Massachusetts College of Pharmacy and Health Science  
Pharmacy Outreach and Education Program (“Program”)

Privacy Notice

This notice describes the type of information the Program will gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your health information and the right to approve or refuse the disclosure of specific information except when the disclosure is required by law. If the practices described in this notice meet your expectations, there is nothing further you need to do. If you have any questions about this notice, or wish to limit our use or disclosure of your health information, please contact the **Privacy Officer** of the Program at the address below. References to “health information” include all medical, dental and other health related information.

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We are required by law to:

- keep your health information private, except for disclosures as authorized above;
- give you this notice of our legal duties and privacy practice with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

You have certain rights regarding the health information that we maintain about you. You have the right to inspect and copy health information that may be in our possession. If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an accounting of disclosures we make of health information about you. You have the right to request a restriction or limitation on the health care matters in a certain way or at a certain location. You have the right to a paper copy of this notice at any time. Please consult our website for further notices and policies on privacy at [www.mcphs.edu](http://www.mcphs.edu).

The Program reserves the right to change this notice, and we reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

If you believe, at any time, we have violated your privacy rights, you may file a complaint with the College or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a complaint with the College, contact Privacy Officer Dennis Lyons, 179 Longwood Avenue, Boston, MA 02115, Ph: (508) 373-0031, e-mail: [dennis.lyons@bos.mcphs.edu](mailto:dennis.lyons@bos.mcphs.edu). All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

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