REQUEST FOR ASSISTANCE
Great Lakes Chapter
Myasthenia Gravis Foundation of America

PATIENT MEDICATION SERVICE FUND

Am I Eligible?

You must meet the following criteria:
1. You have been prescribed a Myasthenia Gravis medication
2. You reside in the state of Michigan
3. Your Total Gross Annual Household Income is at or below 2 times the Federal Poverty Level adjusted for family size (will be considered for each applicant upon receiving the application)
4. You have either:

- **No insurance coverage or benefits for prescription medicines or;**
- **You have prescription drug coverage and are experiencing financial hardship**

Please complete the Hardship Assistance section on the Patient Application

How Can I Apply?

1. Fill out and sign the patient side of the application form
2. Place all required documents together in a stamped envelope:
Original completed and signed application form
Photocopies of proof-of-income documents *(please see Proof of Income section below)*
*3. **Fill out HIPAA form and bring to the doctor that prescribes your myasthenia gravis medications. Save a copy for yourself and have the doctor complete the form and fax a copy to us at: (616)956-0622. DO NOT INCLUDE IN APPLICATION PACKET***

Mail to:
Myasthenia Gravis Foundation of America, Inc.
Great Lakes Chapter
2660 Horizon Dr. SE, Suite 235
Grand Rapids, MI 49546

For your information:

- Keep photocopies of your application and your original income documentation
- You will be notified of your status within 2-4 weeks of receipt of your application
- If you are accepted, you will receive a blue card to take to your pharmacy and will receive a notice of the amount of assistance we can provide for you.
- You must have a copy of a current and completed HIPAA Authorization Form on record with your Prescriber so that your Prescriber may share health information about you with the *Foundation Prescription Assistance* program located at the Myasthenia Gravis Foundation of America, Inc - Great Lakes Chapter office. *(You may have received this form with your application in the mail. To obtain an additional form please call, 800-224-9180 or email us at myasthenia.info@gmail.com)*

What Proof of Income Do I Need to Apply?

Please provide us with one of the following items to show your total gross annual household income:

- Current pay check stubs or W-2 forms for all working members of you household
- Federal Tax Return (Form 1040 or 1040EZ) for the prior tax year
- If you are retired, please send your Social Security, pension or other income statements

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First Name____________________ Last Name ___________________ SS #____ -____-____ Phone (   )__________

Address____ Date of Birth: ____ - ____ - __________

City________________________________State*___________Zip____________County__________________________

Email ____ Male/Female/other ______________________________

The Patient Medication Service Fund is designed to provide prescription assistance to individuals diagnosed with MG. This fund only covers medications used to treat MG. Assistance may be granted to cover co-pays, coverage gaps, and/or partial or full price on prescriptions. Coverage is not granted to cover premiums or deductibles. Application is valid for one year, after which point an updated application is required. **This program is available to those with residence in Michigan.***

Annual Income: _________________ **Number of People in the home (including you) ______**

Do you have any insurance coverage for prescription drugs? Yes __ ***go to PART I*** No __ ***go to PART II***

PART I - If you responded yes to question one, are facing financial hardship, and have prescription drug coverage, please answer the following:

1) **Please check the one that fits your prescription coverage type:**
☐ Medicare Part D ☐Medicaid ☐Employer ☐Other ____________________________________

2) **Patient Declaration of Hardship:**
☐By checking this box, I certify that I am experiencing significant financial hardship, and because of this hardship, I am currently unable to pay for the MG medicines prescribed to me.

PART II - Medications and Medical Conditions
Please list any other medical conditions you are diagnosed with: ____

____

List medications used to treat your myasthenia gravis. **Please give name of medication, prescribed dosage, and current price you pay, and how often it's filled****. If you need additional space, please use the back of the form.

Name of Medication	Prescribed Dosage	Current Price	Frequency the Prescription is filled

***The Great Lakes Chapter reserves the right to conduct price checking on medication. We may request that you have your prescription transferred to a pharmacy offering the lowest price.*

PART III - Medical Contact Information -

*****Please Circle the physician that prescribes myasthenia gravis medication (s)**

General Physician: First Name___________________________ Last Name______________________________________

Clinic Name or Physician Group (write N/A if none)____

Phone Number (___)______________________________ Fax Number (____)__________________________________

Address ____

City __________________ State_____ Zip ___________

Neurologist: First Name______________________________ Last Name ____

Clinic Name or Physician Group (write N/A if none)____

Phone Number (___)______________________________ Fax Number (____)__________________________________

Address ____

City __________________ State_____ Zip ___________

Pharmacy: Name____

Pharmacy Address____ City_______________ Zip _____________

Phone Number (___)______________________________ Fax Number (____)________________________________

Address ____

City __________________ State_____ Zip ___________

APPLICATION CHECKLIST:

___ I have completely filled out each Part of the applications (Parts I - III)
___ I have included my proof of income for everyone in my household (most current pay stubs, federal tax return for prior year, social security/other if retired)
___ I have signed and delivered the HIPAA form to the physician who prescribes my MG medications and obtained a photo copy for my records if desired.
___ My physician has faxed a copy of my HIPAA form to the MGFA - GLC at (616) 956-9234
___ I have obtained a photo copy of my application and attachments for my records
___ I have signed and printed my name, and dated this form.

By signing below, I affirm that my answers and my proof-of-income documents are complete, true and accurate to the best of my knowledge.

I understand that:

- Completing this application form does not guarantee that I will qualify for *Great Lakes Chapter prescription assistance.*
- The MGFA - GLC may verify the accuracy of the information I have provided and may ask for more financial and insurance information.
- Any medicines supported by the Foundation shall not be sold, traded, bartered or transferred.
- The Foundation reserves the right to change or cancel the assistance at any time.
- MGFA - GLC does not provide reimbursement or provide funds directly to applicant, all funds are paid directly to the pharmacy.

I certify and attest that if I receive assistance provided by the Myasthenia Gravis Foundation of America, Inc. - Great Lakes Chapter:

- I will promptly contact the Foundation if my financial status or insurance coverage changes.
- I have a signed copy of a current and completed HIPAA Authorization Form on record with my Prescriber so that my Prescriber may share health information about me with the Myasthenia Gravis Foundation of America, Inc. - Great Lakes Chapter.

____ ____________________
Signature or applicant/guardian/advocate Date

____
Print Name

Return this form and required documentation to:

Myasthenia Gravis Foundation
Great Lakes Chapter
2660 Horizon Dr. SE, Suite 235
Grand Rapids, MI 49546

Great Lakes Chapter
Myasthenia Gravis Foundation of America

PATIENT MEDICATION SERVICE FUND
HIPAA Authorization Form for the Disclosure of Patient Information

To Patient:
The attached authorization is for you and your doctor. If you sign this authorization, you are allowing your doctor to give the Myasthenia Gravis Foundation of America, Inc – Great Lakes Chapter (MGFA –GLC) health information about you that will allow the MGFA-GLC to help you get medication(s) that treat myasthenia gravis. The type of information we need from your doctor would be about the prescription(s) for the medicine you need. This authorization is between you and your doctor only. **Please sign and give your doctor the original signed authorization and keep a copy for your records. This form should not be returned with your application.**

To Physician:
The attached authorization, when signed by your patient, documents the patient's permission for you to share certain medical and personal information with the MGFA - GLC in connection with the MGFA – GLC's patient medication service fund. **This authorization is for your records. PLEASE FAX US A COMPLETED COPY at (616) 956-9234 so we know this step has been completed.**

HIPAA Authorization Form for the Disclosure of Patient Information
FOR Great Lakes Chapter
Myasthenia Gravis Foundation of America

PATIENT MEDICATION SERVICE FUND

To the Patient: The Myasthenia Gravis Foundation of America – Great Lakes Chapter (MGFA – GLC) offers patient medication assistance to help patients who qualify obtain myasthenia gravis medicines at a lower cost. In order to determine your eligibility for the Program and to administer your participation in the Program if you are accepted, the MGFA - GLC, along with its affiliated employees who administer the Program, need to obtain certain information about you from your doctor. **Please complete this Authorization, sign and date it, and return it to your doctor.**

To the Physician: Please retain the original signed Authorization with the patient's records and provide a copy to the patient. Please return this patient Authorization to the MGFA – GLC by fax at: (616) 956-9234
* * *

I request and authorize my doctor, ___________________________________ ("Doctor"), to give the MGFA - GLC, including representatives who work on behalf of the MGFA – GLC Program, information about me and my medical condition, which is necessary to determine my eligibility for the Program and for my continuing participation in the Program if I am accepted, to administer the Program, to account for my withdrawal if I decide to stop participating in this Program, and to evaluate patient satisfaction and the Program's overall effectiveness. The type of information that can be given under this authorization may include:
- ☐ My name and birth date
- ☐ My address and telephone number
- ☐ My social security number
- ☐ Financial information about me
- ☐ Information about my health benefits or health insurance coverage
- ☐ Information on my medical condition, as necessary

I know that I can cancel this authorization at any time by writing to my Doctor at ____ . If I cancel this authorization, then my Doctor will stop providing the MGFA - GLC, and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization. I understand that once my Doctor gives the MGFA - GLC information about me based on this authorization, federal privacy laws may not prevent the MGFA - GLC from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a MGFA - GLC medication assistance program.
This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medication assistance under the Program, whichever is later.
Patient or Personal Representative of Patient ***{Authority to sign on behalf of Patient (if applicable)}***
Signature ____
Date ____
Name (please print) ____
Please return the signed form to your Doctor. You are entitled to a copy for your records.