

\*\*\* REFERRAL FORM \*\*\*



**Faith Community Pharmacy, Inc.**

7033 Burlington Pike, Suite #4

Florence, KY 41042

Phone Number: (859) 426-7837

Fax Number: (859) 426-5708

\*\*\*\* Medication Supply Can Be Limited & Variable; We Have No Contraceptives, Controlled Substances or Narcotics \*\*\*\*

**To obtain assistance from our charitable pharmacy:**

- fax this completed form to the number above
- send electronic prescriptions (e-scribe) to Faith Community Pharmacy (or fax prescriptions to the number above if e-scribe capability is not available)

**WHO IS ELIGIBLE?**

Residents of Northern Kentucky who meet program guidelines.

**WHAT WILL THEY RECEIVE?**

Upon receipt of a Referral form and Prescriptions, the referred individual will receive a phone call offering a one-time 90-day supply of medication AND an opportunity to enroll in our free medication program for one year. To enroll in our program, patients must provide proof of residency, proof of household income and ID. If their household income is at or below 200% of the federal poverty level, they will be enrolled and receive free medications on an ongoing basis. Those who use our services are encouraged to enroll in our program within 90 days of their one-time medication assistance. Failure to enroll within 90 days will require another referral. If an individual is over the income qualification guidelines, we will fill a 90-day supply, once per calendar year, with a new referral from the physician.

***REFERRING INSTRUCTIONS:***

Complete the information below & fax to the number above

Send electronic prescriptions (e-scribe) to our pharmacy

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone #: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Reason For Need:    Low Income    No Rx Insurance    Co-pays Unaffordable    Medicare D Coverage Gap

**REFERRING PRESCRIBER or Partner**

Agency Name and Representative: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Prescriber Name: \_\_\_\_\_ Date: \_\_\_\_\_

Notes:

Large empty rectangular box for notes.