Hillsborough County Florida

Health Care Services Department

Authorization and Release Form for Patient Assistance Program

I hereby grant Hillsborough County Health Care Plan (HCHCP) and its contractor, Pharmacy Administrative Solutions, Inc., (or its successor), to serve as my personal representative (Advocate) for the express purpose of receiving and transferring to me any patient assistance program (PAP) medication(s) The authorized Advocate may communicate with drug companies on my behalf and provide my signature(s) on application forms related solely to the specific medication(s) prescribed by my HCHCP provider(s). I authorize the Advocate to disclose my medical and financial information to drug companies for PAP applications and renewal purposes only.

I understand that it will be solely the determination of the drug companies as to whether or not I will receive medications from their patient assistance program. If I am unable to receive my drugs through a PAP, I may still be able to obtain certain drugs through the HCHCP.

I hereby hold Hillsborough County harmless from disclosure of information to the contracted Advocate or any further disclosures made by the Advocate. I further hold Hillsborough County and its Advocate harmless from anything related or pertaining to my participation in a drug companies PAP. This authorization shall be valid for a period not to exceed 5 years from the date signed unless revoked in writing.

I stipulate that a copy of this signed Authorization and Release Form is as authentic as the original.

Autorización y Solicitud de Relevo para el Programa de Asistencia al Paciente

Por medio de la presente, le concede al Plan de Salud del Condado de Hillsborough County Health y a su entidad contratada Pharmacy Administrative Solutions, Inc., (o su sucesor), a servir como mi representante personal (Advocate) con el Unico propósito de recibir y transferir para envio cualesquiera medicamentos del Plan de Asistencia al Paciente (PAP). El representante autorizado podra comunicarse con las empresas farmaceuticas de mi parte y firmar a mi nombre documentacion relacionada unicamente con los medicamentos recetados por el proveedor o proveedores del Plan de Salud del Condado (HCHCP). Autorizo a mi representante que
solamente provea cualquier informacion medica o financiera a las empresas farmaceuticas para las solicitudes del Plan de Asistencia al pacieute y de renovacion de los mismos.

Entiendo que Ia decisión de recibir o no los medicamentos recaen solamente en las empresas farmaceuticas de acuerdo con su Plan de Asistencia al Paciente. Si no puedo recibir medicamentos a traves del Plan de Asistencia al Paciente, aun podre recibir ciertos medicamentos a traves del Plan de Salud del Condado de Hillsborough (HCHCP).

Relevo de toda responsabilidad al Condado de Hillsborough por cualquier informacion divulgada por el representante personal contrado, ahora y en futuro. Tambien relevo de toda responsabilidad al Condadode Hillsborough y al representante personal por cualquier asunto relacionado con mi participación en los Programas de Asistencia al Paciente de las companias farmaceuticas. Esta autorización sera valida por un periodo de tiempo que no excedena 5 anos a partir de Ia fecha de su firma a menos que se cancele por escrito.

Entiendo que una copia firmada de esta autorizacion es tan valida como el original.

APPLICANT MUST SIGN AND DATE BELOW *I* SOLICITANTE DEBE FIRMAR Y FECHA DE ABAJO

Signature/Firma	Date Signed/Fecha de la firma

Printed Name /Nombre letra de molde	Last 4 digits of SSN/Ultimos 4 digitos del numero de Seguro Social	Client ID/Cliente ID

Health Care Services Department
Applicant / Recipient Acknowledgements and Agreements

Notice of Privacy Practices

I have read or received a copy of Hillsborough County's Notice of Privacy Practices (Notice). I understand that if Hillsborough County uses my personal health care information in a manner that is different than described by the Notice, they must first get my permission.

I am accepting this Notice on behalf of:

____ Myself

or ____Another person as representative
(Parent, guardian, family member, etc.)

_____
If signing for another person(s), print their name(s) here.

Patient Assistance Program

By applying for Hillsborough County Health Care Plan benefits, I agree to complete the necessary paperwork for and apply to obtain no cost or low cost prescription drugs from drug manufacturers' patient assistance programs when requested to do so by Hillsborough County staff or representatives. I understand that if I do not complete the necessary paperwork and apply for these no cost or low cost prescription drugs when requested to do so by Hillsborough County staff or representatives, the Health Care Plan may not pay for these prescription medications or any brand name or generic equivalent.

Falsifying Information

I understand that if I provide information which I know is untrue to obtain Health Care Plan Benefits or other public assistance benefits my benefits may be terminated and I may be prosecuted under applicable law.

Social Security Number Disclosure

In compliance with Section 119.071(5), Florida Statutes (Public Records Law) by this document the Hillsborough County Health Care Services discloses to you that your social security number is requested by the Department for the purpose of verification of information to determine or verify eligibility for Hillsborough County Health Care Plan benefits and other public assistance benefits, identity verification, verification of past or current employment, criminal history checks, income reporting, and asset verification and to process payments for Health Care Plan benefits and other public assistance benefits through the Hillsborough County Clerk of the Circuit Court and will be used solely for one or more of those purposes. The Hillsborough County Clerk of the Circuit Court collects your social security number for the purpose of processing payments on behalf of the Department. The Clerk of the Circuit Court has advised us that your social security number is used by the Clerk of the Circuit Court for no other purpose than stated above.

Release of Information Authorization Agreement

I hereby grant permission to and authorize any bank, building association, insurance company, real estate company, or any financial institution, savings and loan, credit union, or credit agency of any kind or character to disclose to any accredited employee of the Hillsborough County Health Care Services full information as to my past, present or future bank accounts, earnings, insurance policies, property, or legal action for the purposes of determining or verifying eligibility. In connection with my application for assistance, I understand that all information I provide will be verified, which may include computer file matching and that I may be requested to provide other information as a result. I agree that reproductions or copies of this signed release of information authorization are as valid as the original.

☐ **My signature below acknowledges I that I have read each of the statements above and that I will comply with my agreements above.**

_____ _____
Signature ***Date Signed***

_____ _____
Printed Name ***Client ID #***

Health Care Services Department
Applicant/Recipient Acknowledgements and Agreements

REIMBURSEMENT AGREEMENT

CLIENT ID:

FOR VALUE RECENED, I hereby irrevocably and unconditionally agree to reimburse HILLBOROUGH COUNTY for all hospital, medical and financial assistance rendered to me by or on behalf of HILLSBOROUGH COUNTY. I hereby authorize and direct my attorney to protect the interests of HILLSBOROUGH COUNTY for all such hospital, medical and financial assistance and authorize and direct my attorney to make payment from any judgment or settlement on my behalf direct to the Hillsborough County Health Care Services Department for any and all sums due or owing to HILLSBOROUGH COUNTY. I recognize, however, my continuing, personal liability for all such hospital, medical and financial assistance rendered to me by or on behalf of HILLSBOROUGH COUNTY and agree to reimburse the Hillsborough County Health Care Services Department within ten (10) days after demand therefore by the Hillsborough County Health Care Services Department on behalf of HILLSBOROUGH COUNTY. I agree to pay all costs of collection including a reasonable attorney's fee in the event that this obligation is placed in the hands of an attorney for collection.

Signature

Printed Name

Witness

Social Security Number

Date