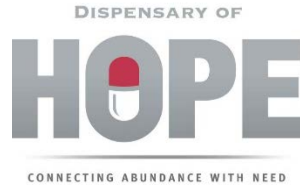


Genesys Regional Medical Center
One Genesys Parkway   Grand Blanc, MI 48439
Phone 810-606-6366   Fax 810-606-7610
Hours of Operation: Monday - Friday, 8 a.m. - 6 p.m.

Staff Instructions

The Dispensary of Hope is a service to provide free prescription medication to low income, uninsured individuals.

An individual must lack prescription drug insurance and have a household income below 200% of the federal poverty level to be eligible for the program.

Please follow these instructions to access services:

1. Review the Dispensary of hope medication inventory list to see if the medication needed is available. Only the drugs on this list are available.

2. Complete the Eligibility Self-Attestation form. This form will determine if the applicant meets the income requirements for the program. Proof of income documents are not required with this form. The applicant may verbally self-attest their income to receive an initial supply of medication. The completed form must be signed by both the applicant and staff member.

3. Complete the Dispensary of Hope Referral form. This form is used to refer the applicant to the Genesee Health Plan. Genesee Health Plan will determine if the applicant qualifies for long term access to Dispensary of Hope Medication.

4. Give the applicant the Dispensary of Hope Patient Information form. This form provides the applicant with information about Dispensary of Hope and the procedures that need to be followed.

5. Fax the referral form and self-attestation form to both the Genesys Pharmacy AND to Genesee Health Plan
   Genesys Pharmacy Fax: 810-606-7610
   AND
   Genesee Health Plan: 810-232-0457

6. Instruct patient to bring all covered prescriptions to the pharmacy. The pharmacy is located in the atrium at Genesys Regional Medical Center. The pharmacy is open Monday through Friday from 8 a.m. to 6 p.m.

Medication List

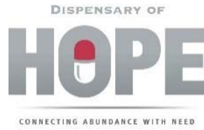
Genesys Regional Medical Center; Updated August 15, 2017

Medication Name	Strength
Albuterol Sulfate Inhalation Solution	0.08%
Allopurinol	300 mg
Allopurinol	100 mg
Amitriptyline HCl	25 mg
Amlodipine Besylate	10 mg
Aripiprazole	10 mg
Aripiprazole	2 mg
Atorvastatin Calcium	10mg
Atorvastatin Calcium	20mg
Atorvastatin Calcium	40mg
Bupropion HCL ER (SR)	150 mg
Bupropion HCl ER (XL)	300 mg
Buspirone HCl	5 mg
Captopril	25 mg
Carbamazepine	200 mg
Carvedilol	25 mg
Carvedilol	3.125 mg
Cetirizine HCl	10 mg
Chlorthalidone	25mg
Ciprofloxacin	500 mg
Citalopram	20 mg
Citalopram	10 mg
Clonidine	0.1 mg
Cyclobenzaprine HCl	10 mg
Digitek (Digoxin)	0.125 mg
Diltiazem HCl ER	180mg
Diltiazem HCl ER	240 mg
Dispensary of Hope Sticker	Small
Divalproex Sodium ER	250 mg
Doxazosin	4mg
Doxazosin	1mg
Doxepin HCl	25 mg
Doxycycline Mono	100 mg
Enalapril Maleate	2.5 mg
Enalapril Maleate	20 mg

Medication Name	Strength
Hydroxyzine HCL	25 mg
Ibuprofen	200 mg
Ipratropium Bromide Inhalation Solution	0.02% (0.5mg/2.5mL)
Lamotrigine	100 mg
Lamotrigine	25 mg
Lansoprazole DR	30 mg
Levetiracetam	500 mg
Levofloxacin	750 mg
Levothyroxine Sodium	100 mcg
Levothyroxine Sodium	125 mg
Levothyroxine Sodium	75 mcg
Levothyroxine Sodium	150 mcg
Levothyroxine Sodium	175 mcg
Levothyroxine Sodium	50 mcg
Levothyroxine Sodium	25 mcg
Lisinopril	5 mg
Lovastatin	40 mg
Meclizine HCl	25 mg
Metformin HCl	1000 mg
Metformin HCl	500 mg
Metoprolol Tartrate	50 mg
Metoprolol Tartrate	25 mg
Montelukast Sodium	10 mg
Naproxen Sodium	550 mg
Nifedipine ER (CC)	30 mg
Nitrofurantoin Mono Macro	100 mg
Omeprazole DR	20 mg
Ondansetron	4 mg
Pantoprazole Sodium DR	40 mg
Paroxetine	20 mg
Penicillin V Potassium	500 mg
Pioglitazone	30 mg
Pravastatin Sodium	40 mg
Prochlorperazine Maleate	5 mg
Ranitidine	150 mg

Escitalopram	10 mg
Esomeprazole DR	20 mg
Famotidine	20 mg
Fenofibrate	145mg
Furosemide	20 mg
Furosemide	40 mg
Glimepiride	2 mg
Glipizide	5 mg
Guanfacine	1 mg
Hydrochlorothiazide	12.5mg
Hydroxychloroquine Sulfate	200 mg

Rosuvastatin Calcium	5 mg
Sertraline	50mg
Simvastatin	20 mg
Spironolactone	25mg
Tamsulosin HCl	0.4 mg
Telmisartan	40 mg
Tolterodine ER	4 mg
Topiramate	25mg
Triamterene/HCTZ	37.5/25 mg
Valsartan HCTZ	160/12.5mg
Venlafaxine	75 mg



ELIGIBILITY SELF-ATTESTATION OF INCOME

APPLICANT NAME:____ **DOB:** ____________________

Part 1. Participant Income Information

- I hereby attest that my current estimated annual income from wages is $____________________
- Additional income sources such as Social Security disability income, workers compensation benefits, dividends, interest, assistance from family, friends or charity, public assistance and/or food stamps, or other sources: $____________________
- Those other sources of income are: ____
- Income for all others living in my household during the same 12-month period $___________________
- Number of individuals in household ___________
- ***Total income from wages and all other sources*** $____________________

Part 2. Insurance Information
I hereby attest that I am not covered by any form of prescription insurance, including Medicare, Medicaid or VA coverage.

Part 3. Signature (Required)
I certify that all of the above information is true and accurate. I understand that this information is to be used to determine eligibility for the Dispensary of Hope and its related access sites. I will notify staff of any changes in employment, income or insurance prior to having additional prescriptions filled.

Applicant Signature: ____ **Date:** __________________

Staff Signature: ____ **Date:** __________________

Attention Staff*: Please compare the Total income in Part 1 above with the 2017 Federal Poverty Guidelines Table below. Applicant must be at or below 200% of Federal Poverty Guidelines and either lack insurance or covered under a plan with no prescription coverage. Patients with Medicaid, Medicare or VA coverage are not eligible for Dispensary of Hope medication.*

2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia effective 1/26/17

Persons in Family/Household	Poverty Guideline	200% FPG
1	$12,060	$24,120
2	$16,240	$32,480
3	$20,420	$40,840
4	$24,600	$49,200
5	$28,780	$57,560
6	$32,960	$65,920
7	$37,140	$74,280
8	$41,320	$82,640
	For families/households with more than 8 persons, add $4,180 for each additional person.	

GENESYS | Ascension

CERTIFICACIÓN DE ELEGIBILIDAD USO FARMACIA UNICA

NOMBRE DEL SOLICITANTE: ___________________________________ **Fec de Nac:** _________________

Parte 1. Información sobre la renta de ingresos

- Yo, la presente doy constancia de mis ingresos anuales son $_____________________
- Ingresos adicionales como ingresos de seguro social por incapacidad, beneficio de compensación, dividendos, interés, asistencia de familia, amigos, o caridad, o asistencia pública y/o estampillas de comida, o otras fuentes: $_____________________
- Otros fuentes de ingresos: ____
- Ingresos de otras personas en su casa durante los 12 meses: $____________________
- Número de personas que viven en su casa: ___________
- ***Ingresos total de su salario y otras fuentes:*** $_____________________

Parte 2. Información de Seguros Por la presente declaro que yo no estoy cubierto por ningún tipo de seguro de prescripción , incluyendo Medicare , Medicaid o la cobertura de VA.

Parte 3. Firma (Requerido) Yo doy fe que toda la información provista es verdadera y exacta. Yo entiendo que van a usar esta información para determinar mi elegibilidad para el Dispensario de Esperanza y otros recursos relacionados a éste. Notificaré a su personal de cualquier cambio de trabajo, ingresos o seguro antes de tener nueva prescripción.

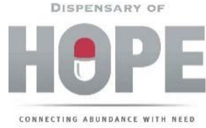
Firma del Solicitante: ____ **Fecha:** ___________________

Firma del Personal: ____ **Fecha:** ___________________

Atención personal: *Por favor, compare el ingreso total en la Parte 1 anterior con la Directrices de pobreza para los 48 estados contiguous y el Distrito de Columbia para el año 2017 incluidas en la tabla a continuación. El solicitante debe ser igual o inferior a 200 % del nivel federal de pobreza y, o bien carecen de seguro o están cubiertos por un plan sin cobertura de medicamentos recetados. Los pacientes con cobertura de Medicaid, Medicare o VA no son elegibles para medicaciónes del Dispensario de Esperanza*

Directrices de pobreza para los 48 estados contiguous y el Distrito de Columbia para el año 2017, efectivo 1/26/17

Las personas en la familia/hogar	Pautas de pobreza	200% FPG
1	$12,060	$24,120
2	$16,240	$32,480
3	$20,420	$40,840
4	$24,600	$49,200
5	$28,780	$57,560
6	$32,960	$65,920
7	$37,140	$74,280
8	$41,320	$82,640
	Para las familias / hogares con más de 8 personas, agregue $4,180 por cada persona adicional.	



Genesys Regional Medical Center
One Genesys Parkway   Grand Blanc, MI 48439
Phone 810-606-6366   Fax 810-606-7610
Hours of Operation: Monday - Friday, 8 a.m. - 6 p.m.

Referral Form

Patient Name:____ DOB:____________________

Patient Address: ____

Patient Telephone Number:______________________________ Allergies________________________

Referring Case Manager/Associate:_____________________________ Phone:____________________

All of the following must be true for the patient to receive up to a 30 day initial supply of medication. Long term eligibility for the program must be verified by Genesee Health Plan in order to receive medication beyond 30 days.

- ❑ Patient has a need for assistance with medication that have been verified to be available in the DOH inventory. (see list of medication on GRMC web site or PHO web site)
- ❑ You have verified the patient does not have any form of prescription drug insurance.
- ❑ Patient reports to you that they are at or below 200% of the Federal Poverty Guidelines. (See chart on GRMC or PHO web sites or on the self-attestation form)
- ❑ The patient has completed and signed the Dispensary of Hope Self-Attestation form to act as the patient's proof of household income. (Find form on GRMC or PHO web site)

Complete list of DOH formulary medications that need to be dispensed:

____

Final Steps:

- Fax this form and self-attestation form to the pharmacy AND to Genesee Health Plan

Genesys Pharmacy Fax:	810-606-7610
Genesee Health Plan Fax:	810-232-0457

- Instruct patient to bring all covered prescriptions to the pharmacy
- Give patient a copy of the Dispensary of Hope Patient Information letter (found on GRMC and PHO web sites)

GENESYS | Ascension

Genesys Regional Medical Center

One Genesys Parkway   Grand Blanc, MI 48439
Phone 810-606-6366   Fax 810-606-7610
Hours of Operation: Monday - Friday, 8 a.m. - 6 p.m.

Patient Information

The Genesys Dispensary of Hope assists low income uninsured patients with their medication needs.

Patients must qualify for the program before coming to the pharmacy for medication.

Patients must complete an application and provide proof of income for the household before receiving medication.

Not all medications are available through The Dispensary of Hope. The medication that you need must be on the medications inventory list for you to receive it. Make sure your doctor prescribes medications that are on our inventory list. The medication inventory list is posted on the Genesys Regional Medical Center web site.

To receive medication beyond 30 days, you must contact the Genesee Health Plan to provide proof of income.

Genesee Health Plan
2171 South Linden Road, Flint MI 48532
844-232-7740
Call Monday - Friday 9 a.m. to 5 p.m. to schedule an appointment

Bring a photo ID, such as a driver's license or state ID card and your Social Security card to your appointment with the Genesee Health Plan. Bring any of these documents that you may have to show your level of income:

Current tax return	Current pay stubs
Letter from employer	Statement from Social Security
Unemployment papers	Disability papers

You will need to reapply to the program with Genesee Health Plan every 12 months if you continue to need medication.

When prescription refills are needed, please call the pharmacy at least 2 days ahead of time to allow time to order needed medication for you. Refills can be called into the pharmacy at 810-606-6366. The pharmacy is located in the atrium of Genesys Regional Medical Center. The pharmacy is open Monday to Friday from 8 a.m. to 6 p.m.

Controlled substances are not covered under the Dispensary of Hope program.

Over the counter items such as Tylenol, aspirin, cold, or allergy medications are not covered under this program.