Ross Patient Assistance Program Application • Instruction Page

The Ross Patient Assistance Program is designed to improve lives by providing a supplemental supply of medically essential nutritional products to financially disadvantaged individuals whose existing resources limit access. All applications are reviewed on a case-by-case basis and must meet specific financial and medical eligibility criteria. Applicants must be legal residents of the U.S. and not have third-party coverage of nutritional therapy.

The program is administered by Abbott Laboratories, the parent company of Ross Products Division. The provision of free nutritional product is a philanthropic activity sponsored by Abbott and Ross; therefore, the Ross Patient Assistance Program is considered the payor of last resort.

Please complete the entire application. Failure to complete any section or to provide all required documentation will delay the review process. Incomplete applications will be returned for further information.

Part I. Information From Physician: Can be completed by the Physician, office staff, or healthcare professional coordinating care but must be signed by the Physician. Please carefully review the certifications and then sign and date the application.

The health care professional responsible for completing the application and associated documentation shall provide such information in accordance with all applicable Federal and state laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996.

Part II. Applicant Information: To be completed by the applicant or applicant's representative.

1. Monthly household income is required. Income includes salary, pension, Social Security income, etc. for all members in the household.
2. Documentation of income is required. Documentation includes a Federal tax return, W2, pay stub, Social Security Benefit Letter, etc., for all members in the household.
3. A copy of Medicare card or letter of Medicaid and/or Social Security denial, or QMB / SLMB statement is required, if applicable.
4. If applicant's existing health benefit does not cover nutritional therapy, a copy of the denial letter OR the published policy that states it is not a covered benefit is required.
5. Please carefully review the applicant certification and then sign and date the application. Provide documentation of authorization if signing for applicant if someone other than a relative of applicant.

Please ensure that the application is complete.
Fax or mail the completed application and associated documentation to Abbott for eligibility review.

Approval & Shipment
The Physician's office and applicant will be notified of applicant eligibility. Upon approval into the Ross Patient Assistance Program, the approved supply of product will be shipped to the applicant's home.

Refill & Requalification
It is the responsibility of the Physician or office staff to contact Abbott 3 weeks prior to the applicant's approved product supply running out. If within the applicant's defined eligibility period, an additional supply of product will be shipped to the applicant's home. If not within the eligibility period, the Physician will be sent a re-enrollment application on behalf of the applicant.

Questions & Comments
Please contact us:
Phone: 1-800-222-6885
Fax: 1-866-483-1305 (toll free)
Hours: Mon-Fri 8am-5pm CST

Applications are available by calling 1-800-222-6885 or visiting www.helpingpatients.org or www.pparx.org

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Ross Patient Assistance Program Application

For Abbott use only

Request #: ________________

Ross Patient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214
Phone 1-800-222-6885 • FAX 1-866-483-1305

Part I: INFORMATION FROM PHYSICIAN

A. PHYSICIAN INFORMATION

❍ Please check circle to indicate change of address.

State License #:	DEA#:	
Last Name:	First Name:	
Professional Designation:	Primary Specialty:	Gender: ❍M ❍F
Office Shipping Address (No PO Box):		
City:	State:	ZIP:
Office Mailing Address:		
City:	State:	ZIP:
Office Contact:		
Phone:	Fax:	

B. NUTRITIONAL THERAPY INFORMATION

Product:	Flavor:	
Amount Needed per day: _________ Calories, Cans or Grams (circle one)	**______% of Daily Caloric Intake Needs**	**Administration: ______ Oral ______ Tube**

Please provide both a primary diagnosis (i.e. cancer, HIV/Aids, diabetes, etc.) and the secondary condition (i.e. involuntary weight loss, cachexia, malnutrition, etc.) that requires the need for nutritional therapy. Applications for Metabolic products and EleCare require a primary diagnosis only.

Primary Diagnosis: ______________________________

Secondary Condition: ______________________________

C. CERTIFICATIONS

1. **Authorization for Release of Health Information:** By signing this Application, I represent to Abbott that I have obtained all necessary Federal and state consents from my patient to allow me to release health information to the Ross Patient Assistance Program.
2. **Physician/Care Coordinator Verification:** I verify that the information provided in this Application is current, complete and accurate to the best of my knowledge. If this applicant is eligible for the Abbott Patient Assistance Program, I understand that Abbott will send the nutritional product to the applicant's home. Abbott reserves the right to request additional information if needed and to change or discontinue this program at any time, without notice. By signing this form, I certify that the applicant is under my ongoing supervision for their nutritional therapy and that I am recommending the aforementioned nutritional product for the applicant. I understand that it is my responsibility to report any adverse events or conditions that may result from the use of the aforementioned nutritional product to Ross Products Division/Abbott Laboratories. I acknowledge that I shall not seek reimbursement for any nutritional product provided hereunder from any government program or third-party insurer. I also understand that the applicant's acceptance into the Abbott Patient Assistance Program is not made in exchange for any explicit or implicit agreement or understanding that Abbott Product will be used, purchased, leased, ordered, prescribed, recommended, or arranged for or provided formulary or other preferential or qualifying status.

Note: Physician may not delegate signature authority. **(STAMPS NOT ACCEPTED)**

Physician's Signature:	Date:

Part II: APPLICANT INFORMATION

Note: Part II of the Application must be attested to by the applicant or applicant's representative. Patients in health care institutions are not eligible. **Applicant must have valid Social Security number to participate.**

A. CONTACT INFORMATION

❍ Please check circle to indicate change of address.

Social Security #:	Date of Birth:	Gender: ❍M ❍F
Last Name:	First Name:	Middle Initial:
Guardian Name:		
Address: (No PO Box):		
City:	State:	ZIP:
Phone:		

B. FINANCIAL INFORMATION

DO NOT SEND ORIGINALS

Attach the most current copies of income documents for you and all members in the household.
Acceptable documents include Federal tax return, SSA-1099, W2, pay stubs or benefits award letter.

☐ **Number of people in household including yourself.** ☐ **Number of children in household under age 18.**

Monthly income for all in household:		Disability	$
Salary /Wages	$	Unemployment	$
Pension	$	Child Support / Alimony	$
Social Security	$	Interest / Dividends	$
Total all sources	$		

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Ross Patient Assistance Program Application

Please Print Applicant Name Below:

RossPatient Assistance Program • 200 Abbott Park Road D-31C AP52S-1 • Abbott Park IL 60064-6214
Phone 1-800-222-6885 • FAX 1-866-483-1305

Part II: APPLICANT INFORMATION, continued

C. HEALTH BENEFIT INFORMATION

Medicare	Does applicant have Medicare?		❍Yes ❍No
	If yes	Check all that apply:	❍Part A ❍Part B
		Attach a copy of applicant's Medicare card.	
		Does the Part B benefit provide coverage for the requested product(s)?	❍Yes ❍No
Medicaid	Has applicant applied for financial assistance (Medicaid, SSI, etc)?		❍Yes ❍No
	If yes	Has the applicant been denied assistance?	❍Yes ❍No ❍Pending ❍QMB ❍SLMB
	If yes	Provide copy of denial dated within 2 years.	
	Does applicant have Medicaid coverage for nutritional therapy?		❍Yes ❍No
	If no	Provide a copy of denial letter OR the published policy stating the nutrition therapy is not covered.	
	Is the applicant eligible for food stamps)?		❍Yes ❍No
Other State/ Government	Does applicant have benefits through other state/government program (i.e., WIC, ADAP)?		❍Yes ❍No
	❍Not Applied ❍Application Pending ❍Waitlisted ❍Accepted ❍Denied		
	If yes	Does the benefit provide (partial or full) coverage for the requested product(s)?	❍Yes ❍No
		Program Name:	Amount Provided:
Private	Does applicant have benefits through private insurance/HMO?		❍Yes ❍No
	If yes	Does it provide (partial or full) coverage for the requested product(s)?	❍Yes ❍No
		Plan name:	Amount Provided:
	If no	Provide a copy of denial letter OR the published policy stating the nutrition therapy is not covered.	

D. REPRESENTATIVE FOR PURPOSES OF PROGRAM

I permit the Ross Patient Assistance Program to speak with the following person(s) about my application and/or care and sign any documents related to the Program on my behalf:

Name:	Relationship:
Name:	Relationship:

E. CERTIFICATION

In the event that I am eligible for the Ross Patient Assistance Program (PAP), I acknowledge that this assistance is temporary and I may be asked to reapply at designated intervals. I also understand that the Program may be changed or discontinued at any time. I agree that I will not seek reimbursement for any products dispensed under the Program from any government program or third party insurer. I acknowledge that the Ross PAP may send me additional information about the Program, or information about alternate or additional financial assistance. I certify that the information I have provided in this Application is correct and complete.

Applicant's Signature:	Date:

Note Applicant's Representative*: If the Applicant is unable to sign, or has designated signature authority, the Applicant's Representative may sign this Application. However, only certain individuals may qualify as the Applicant's Representative for purposes of this Application. An Applicant's Representative must have the requisite knowledge and information regarding the Applicant's financial and health care status to verify that all responses provided are accurate. An appropriate consent from the Applicant, attesting to the Representative's possession of this knowledge or information must be on file if the Applicant's Representative is someone other than a relative of the Applicant. A person or entity in the supply chain of the product to be received through the Program, including a health care provider or pharmacy receiving the free products, may not be named a Representative.*

Signature of Applicant's Representative:	Date:	Relationship

Note: If a consumer assistance or charitable organization, please list name of entity and purpose of entity under Relationship.

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