



APPLICANT INFORMATION

Full Name : _____
First Name Middle Initial Last Name

Date of Birth : ____ / ____ / ____ Gender : Male Female Phone Number : _____

Address : _____
Street Address Apt/Unit #

City, State, Zip-Code

ELIGIBILITY DETAILS

I am currently living in the state of Iowa. Yes No

I am unable to afford my prescription regardless of insurance coverage. Yes No

I understand the prescription received has been donated. Yes No

I understand the medications may not be in a child safe container and waive my rights to the Poison Prevention Packaging Act. Yes No

PERSONS IN HOUSEHOLD ANNUAL INCOME

1	\$30,120
2	\$40,880
3	\$51,640
4	\$62,400
5	\$73,160
6	\$83,920
7	\$94,680
8	\$105,440

My family income is at or below the above levels. Yes No

By my signature, I certify that all information on this form is accurate and complete. I understand SafetNetRx may contact me in the future to verify this information. If the information I have provided is incomplete or inaccurate, and I do not meet the eligibility requirements any services I request may be denied.

Further, I understand that the pharmacy, pharmacist, clinic, and others involved with this program cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.

Privacy Policy SafeNetRx will take all appropriate steps to keep any personal information you share with us confidential. SafeNetRx will not sell, rent, or give away personal information gathered for use in selling other company's products or services. Any information we do gather will be used to improve our relationships with our members. If you have any questions about this privacy policy, you may contact us at repository@safenetrx.org, or call tollfree at 1-866-282-5817 M-F 8:00a.m. to 4:30p.m. CST.

APPLICANT SIGNATURE

DATE