Welvista
Hope and wellness for the uninsured.

Dear Patient,

Welvista's Medication Assistance Program is a non-profit mail order pharmacy and is completely free to low income, **uninsured** South Carolina Residents who qualify. There is no fee to apply and no charge for any medications you receive from Welvista.

- Complete all information on the front of the application and include all necessary documents
- Keep the Notice of Privacy Practices for your records
- Available medications are listed on this website

To participate in our program, complete the application and mail, email or fax everything listed below to Welvista. **Eligibility requirements and detailed instructions are on the back of the application**. If any of the items listed below are not submitted, it will delay the processing of your application.

1. **APPLICATION** - ALL sections must be completed. Make sure you complete the INSURANCE and the ALLERGIES sections on the application.

2. **PROOF OF WHERE YOU LIVE** - This may be a copy of your Driver's License, State ID Card, a utility bill, or any bill with **your** name and current street address printed on it. This should match the street address you list on the application (not your PO Box).

3. **PROOF OF INCOME FOR EVERYONE IN YOUR HOUSEHOLD -** Welvista considers your household to be everyone who lives together under the same roof. If no one in your home has any income, please print out and include a completed No Income form indicating how you pay for housing, food and utilities.

4. **PRESCRIPTIONS -** Make sure they are on the available medications list detailed on this website. If your doctor gave you paper prescriptions, the originals must be mailed (not faxed) to Welvista.

You have three ways to submit your application and supporting documents.

1) MAIL to Welvista 121 Greystone Blvd, Columbia, SC 29210
2) SCAN and EMAIL to applications@welvista.org
3) FAX to 803-254-0892

Remember, if you have paper prescriptions from your doctor, the originals must be mailed to Welvista.

Please call if you have any questions about how to complete your application or what proof you should send. We look forward to helping you. Your application will be processed within 10-14 business days.

Sincerely,
Welvista Patient Services

Welvista
Hope and wellness for the uninsured.

121 Greystone Blvd.
Columbia, SC 29210
803-933-9183
www.welvista.org

Before you mail your application, please check each of the following.

Is this a renewal application?	Yes ❑ No ❑
Is each section completed?	Yes ❑ No ❑
Did you sign and date the application?	Yes ❑ No ❑
Did you attach proof of income?	Yes ❑ No ❑
Did you attach proof of your street address?	Yes ❑ No ❑

PATIENT INFORMATION

Last Name: | First: | MI: | Social Security Number ___-___-____ | Birth Date

Patient Address (where you receive your mail) City State Zip

Patient Address (where you live) (attach proof of street address to application) City State Zip

County in South Carolina | Home#/Cell# | Work or alternate#

Ethnic Origin:
Asian ❑ Hispanic ❑
Black ❑ White ❑ Other ❑

Gender:
Male ❑
Female ❑

Are you a legal resident? Yes ❑ No ❑

List all medications you are allergic to. If no allergies, write "NO."

Doctor/Clinic/Healthcare Provider | Doctor/Clinic/Healthcare Provider's phone#

Circle number of people who live in your household including self:
1 2 3 4 5 6 7 8 9

Do you have (please check) ❑ Health Insurance/Affordable Care Act ❑ Medicare ❑ Medicaid ❑ Family Planning /Healthy Check Up ❑ VA Health
I do not have any medical health insurance ❑

PATIENT ELIGIBILITY INFORMATION

List all household income, gross monthly amounts

Salary/Wages	$ _____
Disability	$ _____
Alimony/Child Support	$ _____
Social Security	$ _____
Pension/Retirement	$ _____
Unemployment/Work Comp	$ _____
Total Gross Household Monthly Income:	$ _____

ATTACH PROOF OF HOUSEHOLD INCOME

Include proof of ALL household income - wages (2 current consecutive paystubs), pension/retirement, social security, SS disability with Notice of Award, child support, alimony, unemployment, worker's compensation, rental income, etc. SEE BACK FOR ADDITIONAL INCOME INFORMATION

AGREEMENT/ DISCLOSURE / RELEASE

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. **I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Health Benefits, or if there is a change in my financial status or my mailing address changes.** I have received Welvista's Notice of Privacy Practices Statement.

Patient/Guardian signature _____ Date _____

WELVISTA USE ONLY

Approved/Denied_____ MR #_____ Keyed_____

Plan ID _____ AC Health _____

Pt Adv_____ SCThrive Yes ❑ or No ❑

Approval Date_____ Exp Date_____

Facility_____ FP #_____

DOCTOR/CLINIC USE ONLY

Doctor/Clinic _____

Hospital _____

HOP# _____ HOP ID# _____

Access Health Group _____

Questions? Call 1-803-933-9183 or visit www.welvista.org

Welvista Application Instructions

To Qualify, you:

- ✔ Must be a legal resident of South Carolina
- ✔ Cannot have Medicare, Medicaid (except Family Planning/ Healthy Connections Checkup), VA Health Benefits, Private Health Insurance or Affordable Care Act
- ✔ Household income must be at or below 200% of the Federal Poverty level. Refer to this chart. →

Return completed application, proof of street address, and proof of income for everyone in your home to:

Welvista
121 Greystone Blvd.
Columbia, SC 29210

2017 HHS Federal Poverty Guidelines**
**Gross income before taxes and/or any deductions

# in Household	Monthly Gross Income	Yearly Gross Income
1	$2,010	$24,120
2	$2,707	$32,480
3	$3,403	$40,840
4	$4,100	$49,200
5	$4,797	$57,560
6	$5,493	$65,920
7	$6,190	$74,280
8	$6,887	$82,640
For each additional person add	697	$8,360

1. PROOF OF PHYSICAL ADDRESS- Provide proof of where you live (street address you listed on the application)

2. PROOF OF INCOME: For each person in your home who has income, attach all of the following items listed below that apply. If you are not sure what to send, call and we will help you.

Job –
- Send 2 recent weeks of pay stubs (within the last 45 days) that are consecutive (with no weeks missing in between) showing your/your household's GROSS income (with any deductions listed), not NET. We cannot accept copies of checks or bank statements.
- You may instead send a signed and dated letter from your/your household's employer stating what work is done, if there are any deductions from pay, the GROSS rate of pay, and the number of hours worked for the last 2 weeks. You may send a completed copy of Welvista's Employer Statement of Income.

Commission –Please send 1 month of documentation stating commission earnings.

Odd jobs/work for family, friends or neighbors – Send a signed and dated letter from those you/your household do work for stating what work is done, the GROSS rate of pay (with any deductions listed), and the number of hours worked for the last 2 weeks.

Self-employed – Send your/your household's most recent Federal 1040 tax return and the Schedule C – Business Profit or Loss worksheet or you may send a completed copy of Welvista's Self Declaration of Income Form. Call Welvista if you need this form.

Unemployment – Send Unemployment Benefit Statement showing the weekly amount received as well as the benefit-year-end date (BYE). It must be clear you are currently receiving benefits. We cannot accept copies of checks.

Social Security Retirement/Social Security Disability – Send the Social Security New Benefit Amount letter showing MONTHLY amount received for the CURRENT year. **If you are the person applying and you receive social security disability you must also send your Notice of Award or entitlement letter from Social Security that shows the month and year you became entitled to disability.** You must be within the first two years of disability when you do not qualify for Medicare. We cannot accept copies of checks or bank statements.

Other Retirement/Pension/Annuity – Send the current benefit statement showing the monthly amount received with any deductions OR a copy of Form 1099. We cannot accept copies of checks or bank statements.

Child Support/Alimony – Send a copy of a current statement from the clerk of court or a copy of the entire divorce decree stating amount received and how often.

No Income – If no one in your home has any income, submit a fully completed No Income form. We need to know how you are paying for your housing, food, and utilities. The person providing support cannot live in same household as the patient. Call Welvista if you need this form.

NOTE: Welvista enrollment is for up to one (1) year. Once approved, you will be eligible for any medications on our current drug list. Medications will be shipped from our pharmacy in Columbia to the address indicated on your application. Prescriptions are filled for a 90 day supply whenever possible.

If you have any questions or need further assistance, please call 803-933-9183, between 8:30am and 5:00pm EST, Monday through Friday, or visit our website at www.welvista.org.
ALLOW 2 WEEKS TO PROCESS YOUR APPLICATION.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BY USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

YOU SHOULD ALSO SHARE A COPY OF THIS NOTICE WITH YOUR FAMILY MEMBERS, FRIENDS, ETC. WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE.

This notice affirms that Welvista is dedicated to maintaining the privacy of your health information. In our operations, we create records regarding you and the benefits/services we provide you. This Notice will tell you about the ways in which we may use and disclose medical information about you. We will also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Maintain the privacy of your health information, also known as PHI
- Provide you with this Notice, and
- Comply with this Notice

We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If there is a material revision to this Notice, we will distribute the new Notice to you within 60 days of the revision. You may obtain a paper copy of the current Notice by contacting Welvista using the contact information we provide at the end of this Notice.

HOW WELVISTA MAY USE AND DISCLOSE YOUR PHI

The law permits us to use and disclose your PHI for certain purposes without your permission or authorization. The following gives examples of each of these circumstances.

1. **For Treatment.** We may use or disclose your PHI for purposes of treatment. For example, we may disclose your PHI to physicians, nurses, and other professionals who are involved in your care.
2. **For Payment.** We may use or disclose your PHI to provide payment for, or stock replenishment of the treatment you receive under the Welvista benefit.
3. **For Health Care Operations** We may use or disclose your PHI for our health care operations. For example, we may verify periodically your eligibility status with the state Medicaid system or other insurance benefits, which may be responsible for the cost-management and planning of your medications.
4. **To the Plan Sponsor** We may disclose your PHI to Welvista executive and planning personnel only for purposes of maintaining your eligibility for enrollment in the plan.
5. **For Health Related Plans and Services** Welvista may contact you about information regarding treatment alternatives or other health-related benefits and services that may be of interest to you.
6. **To Individuals Responsible for Your Care** We may disclose your PHI to a family member or friend who is involved in your medical care provided that you agree to this disclosure, or we give you the opportunity to object to this disclosure. However, if you are unavailable or are unable to agree or object, we will use our best judgment to decide whether this disclosure is in your best interest.
7. **For Audits.** We may disclose your PHI to third parties for audit purposes in connection with grant or public funding assistance for pharmaceutical and medical treatment needs of the patient.

OTHER USES OR DISCLOSURES OF YOUR PHI WITHOUT AN AUTHORIZATON

The law allows us to disclose your PHI in the following circumstances without your permission or authorization.

1. **When Required by Law.** We will use and disclose your PHI when we are required to do so by federal, state, or local law.
2. **For Public Health Risks** We will use and disclose your PHI for public health activities, such as those aimed at preventing or controlling disease, preventing injury, reporting reactions to medications or problems with products, and reporting the abuse or neglect of children, elders, and dependent adults.
3. **For Health Oversight Activities** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities, which are necessary for the government to monitor the health care system, include investigations, inspections, audits, and licensure.
4. **For Lawsuits and Disputes** We may use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request of obtain an order protecting the information the party has requested.
5. **To Law Enforcement** We may release PHI if asked to do so by a law enforcement official in the following circumstances.
    - Concerning a death we believe might have resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena, or similar legal process;
    - To identify/locate a suspect, material witness, fugitive, or missing person
    - In an emergency, to report a crime(including the location or victim(s) of the crime or the description, identity or location of the person who committed the crime)
6. **To Avert a Serious Threat to Health or Safety We** may use or disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to prevent the threat.
7. **For Military Functions/ National Security** Your PHI may be disclosed if you are a member of the US or foreign military forces, and if required to by the appropriate military command authorities. We may also disclose PHI about you to federal officials for intelligence and national security activities authorized by law. We may also disclose PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
8. **Inmates** We may disclose PHI to a correctional facility if you are an inmate or under the custody of a law enforcement official

YOUR RIGHTS RELATED TO YOUR PHI

You have the following rights regarding your PHI that we maintain.

1. **Right to Request Confidential Communication**
2. **Right to Request Restrictions in use of your PHI**
3. **Right to Inspect and Copy your PHI**
4. **Right to Request Amendment to your PHI**
5. **Right to an Accounting of Disclosures**

We are not required to agree to your requests, but will do everything within our means to accommodate any legitimate request.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED, YOU MAY FILE A COMPLAINT WITH WELVISTA'S PRIVACY OFFICER, OR WITH THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

To file a complaint with us, you must submit in writing to the address listed at the end of this Section. **We will not retaliate against you for filing a complaint.**
If you have questions about this notice or would like to exercise one or more of the rights listed in this notice, please contact:

Welvista
ATTN: HIPAA Compliance Officer
121 Greystone Blvd.
Columbia, SC 29210-8002
Tel (803)-933-9183
or
The Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201