PRESCRIPTION DRUG REPOSITORY PROGRAM
INTAKE APPLICATION FORM FOR ELIGIBILITY

Completion of this form meets the requirements under Minnesota Statute 151.555 for obtaining attestation of eligibility to receive prescription drugs or medical supplies through the Prescription Drug Repository Program. This form must be maintained for at least five years.

Questions about completing this form may be directed to Minnesota Medication Repository Program (RoundtableRx) at info@roundtablerx.org

Secure Fax: (866) 254-9105

RECIPIENT INFORMATION

Recipient Name (print or type)	Recipient Date-of-Birth
Recipient Address	
Recipient Phone Number	

By signing this document, I attest that:

(1) I am a resident of Minnesota;

(2) I am uninsured and not enrolled in the medical assistance program or the MinnesotaCare program; I have no prescription drug coverage; or I am underinsured;

(3) I acknowledge that the drugs or medical supplies to be received through the program may have been donated; and

(4) I consent to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

SIGNATURE OF RECIPIENT **DATE**

______________________________ __________________________

For Staff Use:

Eligible:________Yes_________No Reviewed by:_______________________________(print name)

Confirmation of:
Residency Verification:_______
No Prescription drug coverage, underinsured, or uninsured:_______

Valid for one (1) year. Start Date:_________________ End Date:__________________

Local Repository to send copy of this form to Central Repository within 10 days of application approval.

Prepared by the Minnesota Board of Pharmacy. Last updated 10/20/2020