ROSS NUTRITION

Ross Patient Assistance Program

The Ross Patient Assistance Program is designed to provide adult medical nutritional products to financially disadvantaged individuals. 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 payer of last resort.

All applications are reviewed on a case-by-case basis. Financial eligibility is based on current federal poverty guidelines adjusted for household size. All applications will be reviewed and assessed against medical eligibility guidelines established by the program.

Enrollment

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.

Physician Information Section: To be completed by the physician or office staff.

Patient Information Section: To be completed by the patient or legal guardian. Patient or legal guardian must indicate any insurance, federal health care program benefits, or other assistance currently received for any health care costs.

1. Monthly household income is required. Patient or guardian must report all income, including salary, pension, Social Security, etc, for ***all*** members of patient's household.
2. Documentation of income, including federal tax return, W-2, pay stub, etc, for ***all*** members of patient's household is required.
3. A photocopy of patient's Medicare beneficiary card is required, if applicable.
4. A letter of Medicaid and/or private insurance denial is required, if applicable.

Product and Medical Information Sections: To be completed by the physician, office staff, or dietitian involved in the patient's care.

Physician Verification: To be completed by the physician. Physician's actual signature and date are required—no stamps will be accepted.

Patient or Guardian Consent: Patient's or legal guardian's signature and date are required.

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

Approval and Shipment

The physician and patient will be notified of patient eligibility. Upon approval into the Ross Patient Assistance Program, a supply of nutritional product will be shipped to the patient's home.

Refill and Requalification

It is the responsibility of the physician or office staff to contact Abbott Laboratories 3 weeks prior to the patient requiring further nutritional product. If within the patient's defined eligibility period, an additional supply of nutritional product will be shipped to the patient's home. If not within the eligibility period, the physician will be sent a re-enrollment application on behalf of the patient.

Questions & Comments

Please contact us:

Phone: 1-800-222-6885

Fax: 1-847-935-4789

Hours: Mon-Fri 8am–5pm CST

Ross Patient Assistance Program—Medical Nutritionals

Ross Products Division, Abbott Laboratories
200 Abbott Park Road, D-31C, J23
Abbott Park, IL 60064-6161
(800) 222-6885

Fax (847) 935-4789 **Please print or type.** **Request #** _____
For office use only

PHYSICIAN INFORMATION

Name _____ State License # _____

Address (no PO Box) _____

City _____ State _____ ZIP _____

Phone _____ Ext. _____ Fax _____

Office Contact _____ Ext. _____ Fax _____

PATIENT INFORMATION

Patients in health care institutions are not eligible.

Last Name _____ First Name _____ Middle Initial _____

Guardian Name (if applicable) _____

Address (no PO Box) _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Social Security # _____ Date of Birth _____ ☐ Male ☐ Female

Household Income—Monthly (income must include all in household) _____

Source of Income _____ # in Household _____

Attach documentation of income (eg, federal tax return, W-2, pay stub)

Is the patient receiving health care benefits through any of the following programs?

Medicare ☐ Yes ☐ No **If yes, attach a copy of the patient's beneficiary card.**

Private Insurance/HMO ☐ Yes ☐ No **If yes, provide name of insurance/HMO:** _____
If yes, provide a denial of benefits for product requested.

Medicaid, SCHIP, BCMH, WIC, ADAP ☐ Yes ☐ No

If yes, provide name of program: _____

If no, has the patient applied for Medicaid benefits? ☐ Yes ☐ No

If yes, has the patient been denied benefits? ☐ Yes ☐ No ☐ Pending ☐ Waitlisted ☐ QMB
If yes, provide copy of denial or QMB statement.

Has the patient sought any other type of assistance to obtain the product (associations, foundations, etc)? ☐ Yes ☐ No

If yes, explain results.

_____

_____

_____

_____

_____

PRODUCT INFORMATION

Product Requested _____ **Calculated Energy Needs** _____ **Cal/day**

Administration ☐ **Oral** ☐ **Tube** **Calories from Nutritional Therapy** _____ **Cal/day**

MEDICAL INFORMATION

Primary Diagnosis _____

_____

Condition Requiring Nutritional Therapy (eg, involuntary weight loss, cachexia, dysphagia, etc) _____

_____

☐ The program is intended for chronic use. I affirm that the patient needs nutritional therapy for chronic use.

Physician Verification

I verify that the information provided is complete and accurate to the best of my knowledge. I understand that Abbott Laboratories will send the nutritional product to the patient's home. Abbott Laboratories 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 patient is under my ongoing supervision for their nutritional therapy and that I am recommending the aforementioned nutritional product for the patient participating in the Ross Patient Assistance Program. 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.

Physician (STAMPS NOT ACCEPTED)	Specialty (if applicable)	Date

Patient or Guardian Consent for Use and Disclosure of Information

I request and authorize the physician named above to release to Abbott Laboratories, or third parties contracted by Abbott in connection with the Ross Patient Assistance Program (collectively "Abbott"), all information regarding my health and treatment pertaining to the requested nutritional product named above. This authorization shall be valid for one year from the date it is signed. Except to the extent that this authorization has been relied upon by Abbott and the physician named above, I may revoke this authorization by writing to them. I understand that information provided to Abbott, pursuant to this authorization, may no longer be protected under the Health Insurance Portability and Accountability Act, and may therefore be redisclosed. However, Abbott will use and disclose such information solely to assist with the assessment of my eligibility for and enrollment in the Ross Patient Assistance Program, to account for my withdrawal if I decide to stop participating in this program, and as required by law. I understand that this authorization is not a condition for health care treatment and does not guarantee eligibility into or no-cost nutritional product from the Ross Patient Assistance Program.

In the event that I am eligible for the Ross Patient Assistance Program, I understand that the nutritional product will be sent to my home and I acknowledge that this assistance is temporary and that I may be asked to reapply at designated intervals. I also understand that this program may be changed or discontinued at any time. I attest that the information I have provided is correct and complete. I acknowledge that I shall not seek reimbursement for any nutritional product dispensed hereunder from any government program, third-party insurer, or retailer.

Patient or Guardian Signature	Date

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ROSS PRODUCTS DIVISION
ABBOTT LABORATORIES INC.
COLUMBUS, OHIO 43215-1724

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