Dear Potential Client,

We are pleased that you have contacted CMAP *Express* for assistance in getting your prescription medicines. CMAP *Express* has acquired contracts with several drug manufacturers to provide us with bulk donation medications. These contracts allow CMAP *Express* to offer free medications to individuals who meet certain guidelines. Since we do not currently have contracts with all of the drug companies we are only able to offer certain medications through this program.

Enclosed you will find an application packet and instructions. You will need to complete the entire application and return it to CMAP *Express*. Please be sure to answer all of the questions and sign in the appropriate places.

Once we receive your completed application you will be contacted by our office regarding your eligibility.

If you have any questions please feel free to contact our office at 1-888-443-7494,
Monday – Friday, 8 AM – 5 PM.

Sincerely,

Wendy Roy
Program Director

1101 4th Street, Suite 101-A • Alexandria, LA 71301
Phone: 318.443.7494 • Fax: 318.448.4473

Funding provided by:
The Rapides Foundation

Cenla Medication Access Program—Eligibility

1. Client must reside in the State of Louisiana. Proof of residence must be provided (driver's license, ID, or current bill with address).

2. Client's or household income must be at or below chart:
   Proof of income must be provided (if no income—a notarized statement or food stamp benefit sheet is needed). Including copies of tax forms for current year, if no file form 4506-T must be completed.

2025 Guidelines for 300% of the FPL

No. in family	1	2	3	4	5	6	7	8
Income per year	$46,950	$63,450	$79,950	$96,450	$112,950	$129,450	$145,950	$162,450
Income per month	$3,913	$5,288	$6,663	$8,038	$9,413	$10,788	$12,163	$13,538

3. Client must NOT have Medicaid or prescription insurance.

4. Client must be over the age of 18.

❑ New Enrollment
❑ Re-Enrollment

1101 4th Street, Suite 101-A
Alexandria, LA 71301
1-888-443-7494
FAX 318-448-4473

APPLICATION FORM

How did you hear about CMAP? ❑ Physician/ Doctor Referral ❑ TV / Radio ❑ Social media (FB, Instagram, etc)
❑ Community Event / CHA ❑ Other

(Please Print)

Today's date:

Physician's name:

CLIENT INFORMATION

Last Name: First: Middle:

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Widow

What parish do you live in:

Birth date: / /

Age:

Sex: ❑ M ❑ F

Mailing Address: City: State: ZIP Code:

Home phone no.: (   )

Street Address (if different):

Social Security Number:

Mobile phone no.: (   )

Email Address:
By submitting your details, you are indicating your consent to receive messages by phone, text, and/or email regarding CMAP.

Race:
❑ Caucasian
❑ African American ❑ Asian or Pacific Islander
❑ Native American ❑ Hispanic or Latino

Current Employer:
If not working do you consider yourself:
❑ retired ❑ unemployed ❑ never worked ❑ legally disabled

Number in Household: ❑ one(1) ❑ two (2) ❑ three (3) ❑ four (4) ❑ five (5) or more

Please explain and only include client, spouse, and any legal dependents:

Do you currently have prescription insurance? ❑ Yes ❑ No

Do you currently have Medicaid? ❑ Yes ❑ No Medicare? ❑ Yes ❑ No

INCOME INFORMATION

	Client	Spouse	
Social Security	________	________	
Retirement/Pension	________	________	
SSI	________	________	
Unemployment	________	________	
Wages	________	________	
Disability	________	________	
Child Support	________	________	
Rental Income	________	________	
Other:__________	________	________	
TOTAL INCOME:	________	________	____________

By signing client attests that they do not currently have Medicaid, all above information is correct and agrees to inform CMAP of any changes. Client also understands that CMAP records may be reviewed by external auditors from the various drug manufacturers for the purpose of verifying program eligibility.

Client Signature:______________________________Date:____________________

Return Completed Application by mail to:
CMAP Express
1101 4th Street, Suite 101-A
Alexandria, LA 71301
Or Fax to: (318) 448-4473

Patient Medication Sheet

Patient Name: ______________________________ **DOB:** ________________

SSN: ________________

Physician Name/Address/Phone:____________________________________

Are you allergic to any medications?

☐ **None** ☐ **Codeine** ☐ **Penicillin** ☐ **Sulfa** ☐ **Other** ________________

Understands Medications ☐ **Good** ☐ **Poor**

	PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY PRESCRIBED. (Name and strength of **ALL** medications)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

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

NOTICE

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

- Your medical information may be used for treatment, payment, and health care operations. For instance, your information will be used for providing evaluation and tracking of services as well as resources and referral information for the objective of providing low or no cost medications. This will aid in your treatment and health care operations. In addition, Cenla Medication Access Program, in a cooperative effort with Tulane University Health Sciences Center, will monitor for purposes of research how often you obtain and take your medications and will analyze whether appropriate administration of medication reduces the number of hospitalizations.
- Your medical information may also be used and disclosed without your written, consent or authorization if the information does not identify you by any unique identifying number, term, characteristic, image or code.
- Your medical information may also be used without your written consent and/or authorization in judicial and administrative proceedings to the extent allowed by law.
- All other uses and disclosures will only be made with your executed written authorization. You may revoke the written authorization, at any time, by writing:

  Cenla Medication Access Program (CMAP)
  1101 4th Street, Suite 101-A
  Alexandria, Louisiana 71301

YOUR RIGHTS

- You have the right to request restrictions on certain uses and disclosures of protected health information. However, Cenla Medication Access Program (CMAP) is not required to agree to the requested restriction. You may not participate in the research study if you and CMAP do not agree to requested restrictions.
- You have the right to request and receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information. However, CMAP may deny your request if CMAP determines CMAP did not create the information, if the information is not a part of the record, or if the information is already accurate and complete.
- You have a right to receive an accounting of the disclosures of your protected health information made by CMAP in the six years prior to the date on which you request an accounting. However, CMAP does not have to account for disclosures made to carry out treatment, payment and/or health care operations, disclosures made to you, disclosures made to persons or entities involved in your care or any other disclosures exempted from accounting as per 45 CFR 164.528.
- You have a right to receive a paper copy of this notice upon request, if you have received this notice electronically.

CMAP's DUTIES

- Cenla Medication Access Program is required by law to maintain privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to protected health information.
- Cenla Medication Access Program is required to abide by the terms of this notice currently in effect.
- Cenla Medication Access Program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that it maintains. Cenla Medication Access Program will provide you with a revised notice by sending the same through the United States mail to your address which you have supplied to Cenla Medication Access Program.
- You may complain to Cenla Medication Access Program and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint. You may file a complaint with Cenla Medication Access Program by submitting it in written form to:

  Cenla Medication Access Program (CMAP)
  ATTN: Wendy Roy, Program Director
  1101 4th Street, Suite 101-A
  Alexandria, Louisiana 71301
- If you require further information you can contact program at address above or by calling:

  Telephone number (318) 443-7494 or 888-443-7494
- This notice has been effective since July 27, 2001.

CERTIFICATE OF RECEIPT OF NOTICE

I hereby certify that a copy of the Notice explaining uses and disclosure of my protected health information, my rights and Cenla Medication Access Program's duties has been given to me.

____________________________ ____________________

SIGNATURE OF PATIENT DATE

If there is the necessity for a personal representative to sign and date this document due to lack of capacity of the participant/patient, including minority, interdiction, or any other legal reason, the following lines have been provided.

____________________________ ____________________

SIGNATURE OF PERSONAL REPRESENTATIVE DATE

THIS NOTICE AUTHORIZES DELIVERY OF MEDICATIONS FILLED BY *CMAP EXPRESS* AND THE DESTRUCTION OF UNUSED MEDICATIONS

NOTICE

DELIVERY OF MEDICATIONS FILLED BY *CMAP EXPRESS*

- I authorize my prescribing physician, *CMAP Express* staff, and any delivery service contracted by *CMAP Express* as a delivery agent for my medications filled by *CMAP Express*.

DESTRUCTION OF UNUSED MEDICATIONS FILLED BY *CMAP EXPRESS*

- I authorize *CMAP Express* staff to destroy any medication filled in my name and delivered to a delivery agent, as delineated above, for any of the following occurrences: (1) the medication has been discontinued by the prescribing physician, (2) the medication has not been picked up in thirty days, and/or (3) in the event of my death.

- Note: Medications filled by *CMAP Express* should arrive at the prescribing physician's office in approximately one week from *CMAP Express'* receipt of the prescription.

- If you require further information you can contact:

  Cenla Medication Access Program (CMAP)
  ATTN: Wendy Roy, Program Director
  1101 4th Street, Suite 101-A
  Alexandria, Louisiana 71301
  Telephone number (318) 443-7494 or 888-443-7494

- This notice has been effective since May 1, 2006.

CERTIFICATE OF RECEIPT OF NOTICE

I hereby certify that a copy of the Notice explaining delivery and destruction of medications filled by *CMAP Express* has been given to me.

______________________________ ______________________________
SIGNATURE OF PATIENT DATE

If there is the necessity for a personal representative to sign and date this document due to lack of capacity of the participant/patient, including minority, interdiction, or any other legal reason, the following lines have been provided.

______________________________ ______________________________
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

GUIDELINES FOR PROVIDING PROOF OF INCOME

*****If married must include documentation for person applying and spouse*****

If income comes from:	Required Documents
Salary/wages	2 complete months (60 days) worth of check stubs **AND** 2024 income tax return form 1040/1040A/1040EZ – NOT W2 (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form as Verification of Non-Filing)
Unemployment	Documentation should be letter of weekly deposit amount **AND** 2024 income tax return form 1040 (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form as Verification of Non-Filing)
Retirement/Pension Income	Acceptable documents include check stubs or award letters **AND** 2024 income tax return form 1040 (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form as Verification of Non-Filing)
SS/SS Disability/SSI	Acceptable documents include copies of SSA award letter **AND** 2024 income tax return form 1040 (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form as Verification of Non-Filing)
Zero Income	Acceptable documents include notarized statement of zero income, signed statement from MD, or food stamp budget sheet **AND** 2024 income tax return form 1040 (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form as Verification of Non-Filing) ***If you are married and both you and your spouse are claiming zero income both names **MUST** be included on the notarized statement.

***If you are claiming a child under 18 who is not your child (ex. grandchild, niece, nephew) we must have supporting documentation that the child lives in your home full-time. This can be legal documents from court, tax forms showing dependent status or school records.

All documents must be clearly dated within 60 days of application date.

Statement of Income

Please attach a copy of ID

****MUST BE NOTARIZED****

NAME:____

ADDRESS:____

CITY:____

SS#:____

I ____hereby certify the following:
(*full name*)

(Check and complete all applicable items)

_______ I am currently employed or self-employed and certify that my income is $_________ per _________. The source of this income is ______________________

_______ I am currently receiving financial assistance from a friend or family member. Type of assistance _________________ Amount of assistance:________ per __________

_______ I currently have no income.

_______ Other type of income or financial assistance: __________________ Amount of other type of income or financial assistance: $ ___________ per __________

I agree to notify CMAP Express immediately in the event of any change of my financial situation.

I acknowledge and understand that any misrepresentation of my financial situation may result in immediate termination of my eligibility to receive services provided by CMAP Express.

Signed: _______________________________ Date _____________________

State of Louisiana
Parish of ________________

____
(Notary Name and #)

Sworn to and subscribed before me this ________day of ______________2025

____
Witness

____
Witness

****STATEMENT MUST BE NOTARIZED TO BE VALID****

Form **4506-T** (November 2021) Department of the Treasury Internal Revenue Service

Request for Transcript of Tax Return

► **Do not sign this form unless all applicable lines have been completed.**
► **Request may be rejected if the form is incomplete or illegible.**
► **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.	**1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return.	**2b Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ► ____________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . ☐

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☐

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . ☐

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. | / / | / / | / / | / / |

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

Signature (see instructions) | Date

Title (if line 1a above is a corporation, partnership, estate, or trust)

Spouse's signature | Date

Client Checklist

- ☐ All paperwork is signed and dated.
- ☐ All questions have been answered on screening interview.
- ☐ All prescribed medications are listed on application.
- ☐ Proof of income is included (see enclosed guidelines).
- ☐ Most recent federal income tax return Form 1040/1040A/1040EZ -NOT W2 - is included (or if you did NOT file for the most recent tax year, sign and return the attached 4506-T form for Verification of Non-Filing)
- ☐ Include copy of photo identification for proof of Louisiana residency this can include copies of any of the following:
    - Government Issued Photo ID
- ☐ Return all paperwork and supporting documentation to:

By mail: CMAP
1101 4th Street, Suite 101 A
Alexandria, LA 71301
1-888-443-7494

By fax: (318) 448-4473

By email: rxinfo@cmaprx.org
(please include your name in subject line)