DRUG REPOSITORY PROGRAM

Intake Eligibility Application

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

Questions about completing this form may be directed to Minnesota Medication Repository Program at 612-584-4647; fax 866-254-9105; or email info@roundtablerx.org.

RECIPIENT INFORMATION		
Recipient Name	Recipient Phone Number	Recipient Date-of-Birth
Recipient Address		

By signing this document, I attest that:

1. I am a resident of Minnesota;
2. I am not enrolled in the medical assistance program or the MinnesotaCare program;
3. I have no prescription drug coverage; or I am underinsured;
4. I acknowledge that the drugs or medical supplies received through the program may have been donated; and
5. I consent to a waiver of the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

_____ _____

Signature of Recipient Date

For Completion by the Local Repository

Recipient is a Minnesota Resident: Yes ◯ No ◯

Recipient is enrolled in Minnesota medical assistance program or the MinnesotaCare program: Yes ◯ No ◯

Recipient is Uninsured: Yes ◯ No ◯ | Recipient is Under-insured: Yes ◯ No ◯

Recipient is eligible: Yes ◯ No ◯

Valid for (1) year from Start Date (today's date) _____ and expires on _____.

Reviewed by (print name) _____ at (name of Local Repository) _____.

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

Prepared by the Minnesota Board of Pharmacy for RoundtableRx.

July 2022