OFFICE USE:
DATE RCVD_____

CODE_____

Surry County Senior Services
Medication Assistance Program Application

Patient Information

Please fill out all spaces as completely as possible.

****You must be an uninsured resident of Surry County to qualify for assistance through Surry County Senior Services.**

Name: First, MI, Last			
Street Address		Home Phone	
P.O. Box, Apt #		2nd Phone	
City, State, Zip		Date of Birth	
Patient referred by:		**Social Security #**	
		Ethnicity/Race:	
Marital Status: *Circle one* Married Single Separated Divorced Widowed		US Veteran? Yes__ No__	Disabled? Yes__ No__ More than 2 years? Yes__ No__
If married, Spouse's Name: _____	Is spouse participating in program? Yes__ No__ If no, would spouse like to participate? Yes__ No__	Is patient a U.S. Citizen? Yes__ No__ If no, please provide a copy of INS documentation.	
Gender: *Circle One* Male Female	# of People in Household Adults _____ Children____	Employment Status: Employed___ P/F Unemployed___ Retired___ Disabled ___	

Insurance Information

- As of **January 1, 2006** many persons with **Medicare** benefits will be considered ineligible by some pharmaceutical companies, even if you did not choose a **Medicare D** plan.
- If you have any form of prescription drug coverage you will not be eligible for this program.

Medicare? Yes No Medicare D? Yes No ***Please include a copy of your Medicare Card.***	Applied for Medicare 'extra help'? Yes No Call **1-800-772-1213** to apply. *If denied for LIS please provide denial letter.*	**RX insurance?** **Yes No** **IF YES, STOP HERE**
Applied for Medicaid? Yes No	Denied for Medicaid? Yes No *If denied, please provide a denial letter.*	**Medicaid?** **Yes No** **IF YES, STOP HERE**

Financial Information *(This is only a basic guideline as each company has their own guidelines.)*

- **If married-is your annual gross income $28,000 or less ($2,300 monthly)? Yes No**
- **If single-is your annual gross income $20,800 or less ($1,730 monthly)? Yes No**
  (Add $600 per month for each additional dependent)

Did you file a tax return for the previous year? Yes No

If yes, please provide a copy of the first and second page of your federal tax forms.
*If no, please call **1-800-829-1040** to order a transcript.*

Financial documents must be enclosed! Any of the following can be used: Social Security Awards Letter (SSA); Social Security Benefits Statement (call 1-800-772-1213), paycheck stubs (please send stubs from the previous month), Pension Confirmation letter, other documents depending on your financial income. ALL income and changes must be reported and updated annually.

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Patient Name: _____

Financial Information continued:

****Financial documents for the entire household must be enclosed!**

Household Income – Gross Monthly Amounts		Alimony/Child Support	$
Social Security	$	Retirement/Pension	$
SSDI-Social Security Disability	$	Unemployment	$
Wages/Salary	$	Other:_____	$

Household Expenses -- Monthly Amounts		Doctor Bills	$
Mortgage/Rent	$	Prescriptions	$
Hospital Bills	$	Other:_____	$

Checking account balance	$	Savings account balance	$
Money Market/CDs	$	Stocks & Bonds	$

**** If stating no income you must provide a letter explaining how you are living with no income.**

Medical Conditions

- Please provide us with some general health information about yourself.

Please complete the following, if applicable:

Reading Difficulty? Yes No	Hearing Difficulty? Yes No Corrected	Do you drive? Yes No	Other transportation? Yes No
Visual Difficulty? Yes No Corrected	Hand Difficulty? Yes No	# of times in hospital (last 12 months) _____	# of times in ER (last 12 months) _____
Date of last Mammogram: _____	Date of last Pap Smear : _____	Date of last Eye Exam: _____	Date of last Foot Exam: _____

Please provide us with the dates of your last vaccination for the following:

Pneumonia	/ /	Tetanus	/ /	Influenza	/ /

Please circle any of the following conditions you have been diagnosed with:

Arthritis	Asthma	COPD	Depression/Anxiety
Diabetes	Emphysema	Epilepsy	Fibromyalgia
GERD/Acid Reflux	Glaucoma	Heart/Vascular Disease	High Blood Pressure
High Cholesterol	IBS	Migraines	Osteoporosis
Seasonal Allergies	Sleep Disorders	Ulcers-Location_____	**OTHER:**

****Please use additional sheet if you need more space.**

Emergency Contact Information:

Emergency Contact Name:		Power of Attorney? Yes No	
Phone Number:		Relationship:	

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Patient Name: _____

Physician Information

- Please complete the following information about the physicians who will be prescribing your medications.

	Physician's Name	Address	Telephone	Clinic & Specialty
1				
2				
3				

Medication Information

- Please complete for each medication prescribed and indicate which physician from above is the prescribing physician (#1, #2, #3).
- If you are diabetic and use a meter to check your blood sugar please list the name of the meter and the frequency of testing.

	Medication Name	Strength	Directions	Purpose	Physician
Ex:	*Lipitor*	*80*	*1 Tablet, once daily*	*High Cholesterol*	*#1*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

****Please use additional sheet if you need more space.**
****for controlled substances you must enclose a copy of your Social Security card and Photo ID**

Medication Allergies

- If you have ever had allergic reactions to any medications please list it below:

	Medication Name *Ex: Codeine*	Reaction *Ex: Rash, Swelling, Hives, etc.*
1		
2		
3		
4		
5		

****Please use additional sheet if you need more space.**

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Patient Name: _____

Please list below any other conditions or circumstances that we may need to know about:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please read below and sign before submitting your application.

1. I understand that I may not qualify for any or all medications listed on this application and I understand this decision is made by each individual pharmaceutical company and is based on the information that I supply.
2. I understand that this is only an application (DO NOT send prescriptions) to initiate services through Surry County Senior Services. I will be contacted by a patient advocate with an appointment time and I understand that NO medicines will be ordered until that time.
3. I understand that the process normally takes 6-8 weeks AFTER my initial appointment for me to receive any medications I may qualify for. I will be responsible for obtaining my medications until my medications arrive.
4. I understand that each pharmaceutical company has the right to cancel their individual program at any time without any notice to myself, my physician, or my patient advocate and I would be responsible to purchase my medications if that were to happen.
5. I understand that by providing false information or failing to provide any information requested in a timely manner will result in my termination from this program.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature, *if patient is unable to sign* Date