

Copies of Income must be attached or application *will not* be processed

Mount Rogers Medication Assistance Program

Saltville Medical Center

P.O. Box 729

Saltville , Virginia 24370

Phone (276)496-4433/Fax (276)496-5923

Thank you for your interest in the Mount Rogers Medication Assistance Program. Please read this application closely and fill in all areas. If an area doesn't apply to you please draw a line in the blank space. The following items are required before the application for assistance can be processed:

1. Proof of Income (check stub, social security statement, copy of bank statement, W2 form, etc.) To request a copy of your social security benefit letter, call 1-800-772-1213. We cannot accept an income of "0"; therefore, we will need a statement from the person providing you with food and shelter with their income listed.
2. Proof of All Household Income (this includes the income of everyone who resides with you)
3. Copy of your latest Tax Return (if you *do not* file taxes please complete the **Request For Verification of Non-filing**.)
4. Copy of any Insurance Cards.

It is your responsibility to ***promptly*** report any changes in income, insurance status or medications to our office.

****Eligibility is determined by the companies who provide the medication requested. There are no guarantees that you will qualify for assistance. Not all medications prescribed are offered on this program. If your medications are available and you qualify for assistance, it may take 4-8 weeks or longer for you to initially receive your medications. In order to help us know when to reorder your medications, please let us know when you receive medications at home or from other physicians.

Patient Information

Please complete each section. Do not leave any blanks. If an area does not apply to you, put a line through the blank space.

Name:

Last

First

Middle

Social Security Number:

- -

Date of Birth:

/ /

Address:

Physical

Mailing (if different from above)

City

State

Zip Code

Home Phone Number: () -

Alternate number () -

County:

Race: White/Caucasian

Black/African American

Hispanic

American Indian

Asian

Other

Work Status: Employed Full Time

Employed Part Time

Retired

Legally Disabled

Student

Unemployed

Marital Status: Married

Widowed

Single

Divorced

Separated

Gender: Male

Female

Names and ages of others in your household:

Name

Relationship

Age

1

2

3

4

5

Income Information

Please include all sources of income for each person living in the household. Most of the pharmaceutical companies will not accept an income of zero. *We must have documentation of each source of income listed.*

Does anyone in your household receive income from: (please list amounts per *month*)

	<u>Self</u>	<u>Spouse</u>	<u>Other</u>
Salary/wages	\$ _____	\$ _____	\$ _____
Social Security Benefits	\$ _____	\$ _____	\$ _____
SSI/SSD	\$ _____	\$ _____	\$ _____
VA Benefits	\$ _____	\$ _____	\$ _____
Pension	\$ _____	\$ _____	\$ _____
Black Lung	\$ _____	\$ _____	\$ _____
Unemployment	\$ _____	\$ _____	\$ _____
Food Stamps	\$ _____	\$ _____	\$ _____
Rent Assistance	\$ _____	\$ _____	\$ _____
Fuel Assistance	\$ _____	\$ _____	\$ _____
Other	\$ _____	\$ _____	\$ _____

Assets:

Checking: \$ _____

Savings: \$ _____

IRA/CD: \$ _____

Stocks/Bonds: \$ _____

Other: \$ _____

Medication Information

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Name of Medication: _____

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Diagnosis: _____

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Name of Medication: _____

Taken How Often: _____

Monthly Cost: \$ _____

Diagnosis: _____

Medical Information

Physician's Name _____

Name of Physician's Practice/Clinic _____

Physician's Address _____

Physician's Phone Number () - _____

Do you have any drug allergies? yes no

If so, please list: _____

The following form (*Request For Copy or Transcript of Tax Form*) is for you to complete only if you do not file taxes.

To complete the form you must fill in the following lines:

- 1a: Name
- 1b: Social Security Number
- 2a: Name of Spouse (if applicable)
- 2b: Spouse's Social Security Number
- 3: Current Address
- *Skip Sections 4 - 12
- *Both Patient and Spouse must sign and date the form.

Mount Rogers Medication Assistance Program Disclaimer/Agreement Contract

I _____ understand that the Pharmacy Connection program is being provided to me as a courtesy and a privilege by the Saltville Medical Center and the pharmaceutical companies enrolled in this program. The medication can only be ordered with a valid prescription from a health care provider. I also understand that the purpose of this program is to provide medication for individuals who have no prescription coverage and meet the program's financial criteria. I agree that all information given related to my income and lack of coverage is true. I understand any false information given can be a liability. I also understand that it is my responsibility to notify the program director of any change in my income status or insurance coverage.

I _____ understand that it is the responsibility of myself, the patient, to inform my health care provider, at least six weeks in advance, before my medication will run out. At this time the medication will be reordered, if still available through the Pharmacy Connection and if the health care provider still feels the medication is required. I also understand that I have two weeks from the time of notification to pick up my medication. After the two weeks it will be up to the discretion of the health care provider to dispense medication to other patients in need of this medication. I also understand it is not the responsibility of the physicians if the medication does not arrive before my medications run out. I understand that may happen occasionally and should this occur it will be my responsibility to obtain a prescription from my health care provider and purchase the medication from a pharmacy of my choice. I assume all the responsibility for problems that could arise due to the lack of medication.

All of my questions have been answered and with no further questions, I agree to the above contract by signing below.

Signature _____

Date _____

Permission Form

I give my permission for the employees of the Mount Rogers Medication Assistance Program at the Saltville Medical Center to release my information (medical, income, etc.) to pharmaceutical companies in order to assist me in obtaining needed medications. I also give my permission to release my information to share this information with my physician(s) or other health care providers in order to obtain prescriptions for my medications. This permission will be valid until it is withdrawn by myself in writing.

Applicant's Signature _____ Date: _____

I give my permission for the Mount Rogers Medication Assistance Program and the (Name of Your Clinic) _____ to transfer/exchange my information within the medication assistance program in order to best assist me in obtaining my medications. This permission will be valid until it is withdrawn by myself in writing.

Applicant's Signature _____ Date: _____

Signature Waiver

I certify that the information I have supplied the Saltville Medical Center is accurate to the best of my knowledge. I hereby authorize the designated Patient Assistance Advocates of the Mount Rogers Medication Assistance Program to sign my name on the necessary pharmaceutical form(s) that may be required for ordering my medications.

Applicant's Signature _____ Date: _____

Printed Name _____