# MT. ROGERS MEDICATION ASSISTANCE PROGRAM


*****FIVE OFFICES TO SERVE YOU******

*Saltville Medical Center, P.O. Box 729, Saltville VA 24370*
*Phone: 276-496-4433 Fax: 276-496-5923*

*Meadowview Community Health, P.O. Box 297, Meadowview, VA 24361*
*Phone: 276-944-3999 Fax: 276-944-3882*

*Twin City Medical Center, 2195 Euclid Ave. Suite 6, Bristol, VA 24201*
*Phone: 276-699-5179 Fax: 276-466-8870*

*Mt. Rogers MAP, P.O. Box 386, Marion, VA 24354*
*Phone: 276-378-0063*

*Tazewell Community Health, 583-C Riverside Drive, North Tazewell, VA 24630*
*Phone: 276-979-9899 Fax: 276-979-9798*


**Thank you for your interest in the Mt. Rogers Medication Assistance Program. The following items are required when submitting an application:**

1. **Proof of all household income (check stubs, social security benefits, etc.)**
   **(To request a copy of our social security benefit letter, call 800-772-1213)**
   **It is difficult to process an application with an income of "0". Please try and provide a statement from the person providing you with food and shelter with their income listed.**
   **It is your responsibility to promptly report any changes in household income, insurance status, or medications to our office.**

2. **Copy of Tax Return**
   **If you file taxes, we will need a copy of the first 2 pages of your tax return. It you do not file taxes, please complete the attached form 4506-T.**

*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 a physician.*

*Section A: Applicant Information*

*NAME:*_____

*SSN:*_____ *DATE OF BIRTH:*_____

*ADDRESS:*_____

*CITY:* _____ *ZIP:* _____

*COUNTY:*_____ *PHONE#:*_____

*RACE:*
*Work Status:*
*Marital Status:*
*Gender:*

*Names and Ages of Others in Your Household:*

| *Name* | *Relationship* | *Age* |
| --- | --- | --- |
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****Please provide documentation of each source of income listed*

*HOUSEHOLD INCOME*

*Salary Wages*_____

*Social Security Benefits*_____

*SSI/SSD*_____

*VA Benefits*_____

*Pension*_____

*Unemployment*_____

*Other*_____

*Do you have any health insurance?*

*If yes: ___Medicaid___Medicare___Private___Other (please provide copy of card)*

*Do you have prescription insurance? ___yes ___no*

**PLEASE COMPLETE THE FOLLOWING PAGE ONLY IF YOU DID "NOT" FILE INCOME TAXES FOR THE PREVIOUS YEAR**

**IF YOU DID FILE TAXES, YOU MUST SUBMIT A COPY WITH THIS APPLICATION**

Form **4506-T**
(Rev. September 2013)
Department of the Treasury
Internal Revenue Service

# Request for Transcript of Tax Return

▶ **Request may be rejected if the form is incomplete or illegible.**

OMB No. 1545-1872

**Tip.** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Return or Account Transcript" or call 1-800-908-9946. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return.** There is a fee to get a copy of your return.

| | |
|---|---|
| **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** If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number.

**Caution.** *If the tax transcript is being mailed to a third party, ensure that you have filled in lines 6 through 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy. Once the IRS discloses your tax transcript to the third party listed on line 5, the IRS has no control over what the third party does with the information. If you would like to limit the third party's authority to disclose your transcript information, you can specify this limitation in your written agreement with the third party.*

**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 1120A, Form 1120H, Form 1120L, 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 2011, filed in 2012, will likely not be available from the IRS until 2013. 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.

_____ _____ _____ _____

Check this box if you have notified the IRS or the IRS has notified you that one of the years for which you are requesting a transcript involved **identity theft** on your federal tax return . . . . . ☐

**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, partner, 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.** *For transcripts being sent to a third party, this form must be received within 120 days of the signature date.*

| | | |
|---|---|---|
| **Sign Here** | ▶ **Signature** (see instructions) | **Date** / Phone number of taxpayer on line 1a or 2a |
| | ▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust) | |
| | ▶ **Spouse's signature** | **Date** |

Physician Name_____

Name of Practice/Clinic_____

Physician's Mailing Address_____

City, State, ZIP_____

Phone_____

**Please list all current medications:**

| Medication | Strength | Dosage |
|---|---|---|
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**ALLERGIES:** _____

I, _____, understand that assistance is being provided to me as a courtesy and privilege by SVCHS and the pharmaceutical companies enrolled in this program. The medication can only be ordered with a valid prescription for a health care provider. I also understand that the purpose of this program is to provide medication for individuals who have no prescription drug coverage and meet the program's financial criteria. I agree that all information given is true. I understand that it is my responsibility to notify my advocate of any change in my income or insurance coverage.

I, _____, understand that it is my responsibility to notify my advocate should I receive any of the medication at my home or should I receive it from my health care provider's office. I also understand that it is my responsibility to pick up my medications in a timely manner. I assume all the responsibility for problems that could arise due to lack of medication and understand that it is not the responsibility of the physicians or the advocate should I run out of medication. I understand that it is my responsibility to purchase my medication from a pharmacy should I run out.

All of my questions have been answered and I agree to all of the above

Signature_____Date_____

## Signature Permission Form

I give permission for the employees of SVCHS to release my information to pharmaceutical companies in order to assist me in obtaining needed medications. I also give permission to share this information with my physicians or other health care providers in order to obtain prescriptions for my medications. This permission will be valid until withdrawn by me in writing.

Signature_____Date_____

## Signature Waiver

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

Signature_____Date_____

Printed Name_____