Mt. Rogers Medication Assistance Program

FOUR OFFICES TO SERVE YOU

Saltville Medical Center: PO Box 729, Saltville VA 24370
Phone: 276-496-4492 Fax: 276-496-5923

Meadowview Health Clinic: PO 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: 276-591-5803 Fax: 276-591-3677

Tazewell Community Health: PO Box 648, Tazewell VA 24651
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**
   - This can consist of a tax return of the current year, a month's worth of pay stubs for the current month (2 if you are paid bi-weekly or 4 if you are paid weekly), social security benefits letter of current year, or unemployment statement letter
   - If you did not file taxes for the current year, you will need to fill out the 4506-T form within this application.
   - It is your responsibility to promptly report any changes of household income
2. **Copy of photo ID.**
3. **Copy of insurance cards (if applicable)**

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.**

- This program is a service to our patients and the medications received are from the pharmaceutical company. We are in no way responsible for determining requirements and the eligibility for these companies.

- If you fail to let us know when you are running low on your medications or your medications are delayed, we **WILL NOT BE HELD RESPONSIBLE.** It will be your responsibility to consult with your healthcare provider to find an alternative source until your medication arrives.

- Once you are enrolled and your medication has arrived, you will receive a letter in the mail stating your medication is available for pickup. You will have 30 days from the date on the letter to pick your medication up. If you have not picked up your medication within the 30 days, your medication will be returned to the pharmaceutical company, and you may no longer be eligible for the Medication Assistance Program.

- If your health care provider is an outside provider, they will contact you once your medication arrives. If you are unsure of the status of your medication, please call your provider's office to make sure it's not at their office. If it's not, call the number listed above to your MAP office and we will check with the pharmaceutical company regarding your medication status.

MT. ROGERS MEDICATION ASSISTANCE PROGRAM APPLICATION

APPLICANT INFORMATION					
Last Name		First		M.I.	
Social Security No.		Date of Birth			
Address					
City		State		ZIP	
County		E-mail Address			
Home Phone		Cell Phone			
Gender		Marital Status			
Racial or Ethnic Group	American Indian/Alaskan ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino ☐ White/Caucasian ☐ Other ☐ Refused to Respond ☐				
Employment Status					
Do you have any health insurance?	Yes ☐ No ☐	If yes what type? *(Please provide copy of card)*			
Do you have prescription insurance?	Yes ☐ No ☐	If yes what type? *(Please provide copy of card)*			

NAME AND AGE OF OTHERS IN YOUR HOUSEHOLD					
Name		Relationship		Age	
Name		Relationship		Age	
Name		Relationship		Age	
Name		Relationship		Age	
Name		Relationship		Age	
Name		Relationship		Age	

HOUSEHOLD INCOME	
Please provide documentation of each source of income listed.	
Salary/Wages	
Social Security Benefits	
SSI/SSD	
VA Benefits	
Pension	
Unemployment	
Other	

INSURANCE INFORMATION

If you have <u>ANY</u> form of health insurance, please provide us with a copy of your insurance cards.

INSURANCE:
Do you have health insurance? ☐ Yes ☐ No
Is the insurance through your current employer? ☐ Yes ☐ No
Does your insurance have prescription drug coverage? ☐ Yes ☐ No
Have you been denied a prior authorization for your medications? ☐ Yes ☐ No

MEDICAID:
Have you applied for Medicaid? ☐ Yes ☐ No
If yes, what is the current status of your application? ☐ Approved ☐ Denied ☐ Pending ☐ Have not applied
Do you plan on applying for Medicaid? ☐ Yes ☐ No ☐ Already applied
If you have Medicaid, have you been denied a prior authorization for your medications? ☐ Yes ☐ No

MEDICARE:
Do you have Medicare? ☐ Yes ☐ No
If yes, what coverage do you currently have? ☐ Part A (Hospital) ☐ Part B (Medical) ☐ Part C (Medicare Advantage) ☐ Part D (Prescription)
If you have ***Part D***, are you currently in the "Donut Hole" or coverage gap? ☐ Yes ☐ No
If yes, how much have you spent out of pocket on prescriptions? $_____
If you do have ***Part D <u>and</u> are currently in the "Donut Hole"/coverage gap***, please provide us with the additional documentations with this application: * Printout from your pharmacy showing how much you have spent out of pocket for the year (you can ask your pharmacist for this) * Explanation of Benefits (EOB) from your insurance company showing that you have reached the coverage gap.

MEDICAL INFORMATION	
Physician Name	
Name of Practice/Clinic	
Physician's Mailing Address	
City, State, Zip	
Phone	

PLEASE LIST ALL MEDICATIONS YOU ARE REQUESTING *(A prescription must be provided for each requested medication.)*

Medication	Strength	Dosage

Allergies	

PLEASE COMPLETE THE FOLLOWING PAGE <u>ONLY IF YOU DID NOT FILE INCOME TAXES FOR THE PREVIOUS YEAR</u>.

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

Form **4506-T** (June 2019)

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. 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 "Get a Tax Transcript..." under "Tools" 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 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**

DISCLAIMER AND SIGNATURE

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 from 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	