Medication Assistance Application

New Patient Check Sheet

Please attach the following information to your application and return to:

<u>Laurel Fork Location</u>:

Medication Assistance Program
Tri-Area Community Health
PO BOX 9
14558 Danville Pike
Laurel Fork, Virginia 24352

Direct Phone Number: (276) 398-1206

Serving: Laurel Fork, Floyd, Stuart, Grayson, & Fries Locations

<u>Ferrum Location</u>:

Medication Assistance Program
Tri-Area Community Health
180 Ferrum Mountain Road
Ferrum, Virginia 24088

Direct Phone Number: (540) 346-6134

Serving: Ferrum and Floyd Locations

- ✓ Completed patient application.
- ✓ Complete list of <u>all</u> current medications with strength and dose.
- ✓ Proof of income for all members of your household. Household is everyone under the same roof, whether related or not. (If you have questions about what this is, please call us and we will tell you what you need to bring.)
- ✓ If you filed taxes for last year, we will need to have a copy of these. If you do not file taxes, we will need to know.
- ✓ Copy of all insurance cards (front and back sides), including a copy of your Medicare card.
- ✓ Any doctor information that you can provide us with.
- ✓ If you have any problems filling out this application, or understanding it, please feel free to give us a call to make an appointment.

Please call appropriate location (phone numbers listed above following address) with any questions. We will be more than happy to help you.

In approximately six (6) to eight (8) weeks, your medication(s) will be sent to your doctor's office. **Please call appropriate location: Laurel Fork at (276) 398-1206 or Ferrum at 540-346-6134 and let us know when you receive your medications.** This is the only way that we will know when to reorder your medicine so that you will not run out. If you have any questions, please feel free to call us. Thank you!

Medication Assistance Application

Applicant Information

Name:				
Date of birth:	SSN:	Phone:		
Current address:				
City:	State:	ZIP Code:		
County:	Marital Status: Married	Single	Divorced	Separated
Employed	Unemployed	Disabled	Retired	
US Citizen ______Yes	Male ____ Female____	**Are you allergic to any medications?**		

Physician Information

Current physician:		
Physician address:		DEA #
City:	State:	Zip:
Phone:	Email:	Fax:

Income Information

Please list monthly income for entire household (household is everyone living under the same roof, whether related or not)	
Income: $	Source:
Income: $	Source:
Income: $	Source:
Income: $	Source:
Income: $	Source:
Number of Adults in household:	Number of children under 18 in household:
Did you file taxes last year?	*If yes, we will need a copy of that tax return as part of your proof of income.*

Insurance Information

Do you have health insurance?	Name of insurance company:	
Do you have prescription drug insurance?	Name of insurance company:	
Are you covered by any type of Patient Assistance program now?	If so, please list:	
Do you have a Medicare Part D Card?	If not, do you plan to?	Did you qualify for extra help with Medicare Part D?

Medication (please list ALL medications that you are currently taking)

Medication	Strength	Dosage

I certify that the information provided in this application is correct to the best of my knowledge.

Signature of applicant:	Date:

Please complete this page and attach all requested information.

Medication Assistance Program Consent and Release

I understand that I am requesting medication to be ordered for me through the Medication Assistance Program (MAP) through Tri-Area Community Health.

I understand that if medications are delivered to Tri-Area Community Health, they are dispensed through Tri-Area Community Pharmacy and there is a minimal dispensing fee.

______
Initials

Exchange of Information

I authorize a representative of Tri-Area Community Health Medication Assistance Program to inspect my medication records whenever necessary to obtain pertinent information needed to order medications through The Pharmacy Connection. I also authorize the MAP caseworker to discuss my medical needs with my physician when necessary and obtain prescriptions.

I give my permission for the medication assistance program caseworker to release my information (medical, income, etc) to the drug companies in order to assist me in obtaining needed medications. This authorization remains in effect as long as MAP is assisting me or until I revoke it in writing.

Name ____(please print clearly)

Signature ____

Date ___________________________________

Signature Authorization

I authorize a representative of the Medication Assistance Program through Tri-Area Community Health to sign forms on my behalf when ordering medications for me through The Pharmacy Connection. This signature authorization remains in effect as long as MAP is assisting me or until it is withdrawn by me in writing.

Name ____(please print clearly)

Signature ____

Date ___________________________________