## 2016 PRESCRIPTION ASSISTANCE PROGRAM—APPLICATION

**PATIENT NAME**: _____ **DATE OF BIRTH**: __/ __/ __
Last First M.I.

**ADDRESS**: _____
Street City State Zip

**HOME PHONE**: (____) _____ **SOCIAL SECURITY NUMBER**: _____-____-_____

**GENDER**: ☐ Male ☐ Female **MARITAL STATUS**: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

**Are you a U.S. Citizen**? ☐ Yes ☐ No **Race**: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

**Do you have health insurance coverage**? ☐ No, uninsured ☐ Yes
If YES, TYPE: ☐ Medicare ☐ Medicaid/Medical Assistance ☐ Private Insurance
☐ Adult Basic Care ☐ Other: _____

**Does this plan cover prescriptions?** ☐ No ☐ Yes Type: ☐ Cap ☐ Co-pay ☐ Deductible

**FAMILY SIZE: Total number in household, including applicant: _____**
**Number of Adults: _____ Number of Children under 18 years of age: _____**

**EMPLOYMENT STATUS OF APPLICANT:** ☐ **Full** ☐ **Part-Time** ☐ **Retired** ☐ **Seasonal** ☐ **Unemployed**
☐ **Declared Disabled by Social Security—Date of Disability: _____**

**CHECK THE SERVICES BELOW YOU RECEIVE:**
☐ **Child Support** ☐ **Food Stamps** ☐ **Medicaid** ☐ **Pace** ☐ **PaceNet**
☐ **Social Security** ☐ **SSDI—Date of Disability** _____/_____/_____ ☐ **SSI**
☐ **Medicare A** ☐ **Medicare B** ☐ **Medicare D** ☐ **Medicare Prescription Card**
☐ **VA Benefits** ☐ **Private Insurance-Name of Plan** ☐ **RX Coverage**

**If you have medicare have you applied for Low Income Subsidy?** ☐ **Yes** ☐ **No**

**LIST GROSS MONTHLY INCOME FOR ALL PERSONS IN YOUR HOUSEHOLD:**
***If you have stated that you have NO INCOME, we will need a notarized letter or a letter from a social service agency for proof.***

| | Monthly | | Monthly |
|---|---|---|---|
| Wages/Self Employment | $ | Pensions/Retirement | $ |
| Social Security | $ | Child Support | $ |
| Social Security Disability | $ | Worker's Compensation | $ |
| Unemployment Compensation | $ | Support from Family/Friends | $ |
| Welfare (Cash Assistance) | $ | Other Income | $ |
| Bank Interest or Dividends | $ | | |
| TOTAL INCOME All Sources: | | $ | |

***I hereby authorize the release of any information regarding my medical condition and financial need for the purposes of rendering services by BCCHA, its employees and affiliates. I also acknowledge that the information provided is true and correct to the best of my knowledge.***

***Signature:*** _____ ***Date:*** _____

***If the above is given on the patient's behalf, relationship to the patient:*** _____
***Reason:*** _____

**2015 PRESCRIPTION ASSISTANCE PROGRAM—APPLICATION –page 2**

**PATIENT NAME**: _____ DATE OF BIRTH: __/ __/ __
Last First M.I.

Please list the full name (s) and complete address of the doctor (s) prescribing your medications:

**PRIMARY DOCTOR:** _____ **(  )** _____
Name Phone

**ADDRESS:** _____
Street City State Zip

**Other DOCTOR/MEDICAL SPECIALIST:** _____(___)_____
Name Phone

**ADDRESS:** _____
Street City State Zip

**How much do you spend monthly on out-of-pocket medical expenses, including prescription drugs?:**

_____

**MEDICATIONS:**
Please fill out your medication information as completely as possible:

| **Medication Name:** | **Dosage:** | **Prescribing Doctor** | **Pharmaceutical Co. ****(BCCHA only)** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |

Do you have any allergies to certain medication? _____

**Please call Beaver County Cancer & Heart Association at 724-774-6600 to schedule an appointment. You will need to bring in proof of household income. You may also print this application, complete it and bring it with you to the appointment.**

# *Patient Consent and Release for Exchange of Information*

## *Application for the Provision of Care*

I certify that the information I have provided in my application is accurate and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that other documents will be required to provide proof of income. I give permission by verify my income through the Department of Social Services, Social Security Administration, my employer, Veterans Administration and any other company, business, organization from which I receive income.

By signing the enclosed application, I authorize representatives of Beaver County Cancer & Heart Association Pharmaceutical Assistance Program to ask necessary information of my health care providers, to complete applications for medication assistance and to share this information with pharmaceutical companies as required.

Signature: _____

Date: _____