MedAssist of MHC
Bassett Family Practice, & Patrick County
315 Hospital Drive, Suite 203
Martinsville, VA 24112
Telephone: 276-638-0787 * Fax: 276-638-2430

How did you find our about MedAssist? _____ **Date:** _____

A. GENERAL PATIENT INFORMATION

SOCIAL SECURITY NUMBER: _____-_____-_____ Doctor_____

NAME: (FIRST _____ (MIDDLE INITIAL)____ (LAST)_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: (HOME): (_____) _____ (2ND PHONE): (_____) _____

THE COUNTY/CITY YOU LIVE IN_____ **ARE YOU A U S CITIZEN?** YES OR NO

ARE YOU A VETERAN? YES OR NO (Circle One)

GENDER: ☐FEMALE ☐MALE BIRTHDATE: _____/_____/_____

RACE: ☐CAUCASIAN ☐AFRICAN-AMERICAN ☐ASIAN ☐HISPANIC ☐NATIVE AMERICAN ☐OTHER

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOW ☐SEPARATED

EMPLOYMENT STATUS: ☐RETIRED ☐DISABLED ☐EMPLOYED ☐SELF-EMPLOYED ☐ UNEMPLOYED ☐ OTHER

B. ELIGIBILITY INFORMATION

MEDICAL COVERAGE INFORMATION: PLEASE CHECK ALL THAT APPLY

☐EMPLOYER/GROUP INSURANCE or PRIVATE/SELF-INSURED ☐MEDICAID ☐MEDICAID QMB or SLH ☐VA MEDICAL BENEFITS

☐MEDICARE ☐ WITH MEDICARE-D ☐UNINSURED

ARE YOU ENROLLED IN ANY PHARMACEUTICAL COMPANY PATIENT ASSISTANCE PROGRAMS? ☐YES ☐NO

ARE YOU A PATIENT AT ANY LOCAL CLINIC? ☐ **YES** ☐ **NO** **If yes, which one**_____

PLEASE ATTACH A COPY, FRONT AND BACK, OF THE FOLLOWING:
DRIVER'S LICENSE OR STATE-ISSUED PHOTO IDENTIFICATION ☐ **SOCIAL SECURITY CARD** ☐

MEDICARE OR OTHER INSURANCE CARD(S) ☐

DO YOU FILE FEDERAL INCOME TAXES. ☐**YES** ☐ **NO** **(If you do not file taxes, check here** ☐ **4506 needed.)**

HOUSEHOLD INFORMATION: How many people are in your household? _____ **PLEASE LIST EVERYONE IN HOUSEHOLD**

FULL NAME	RELATION TO PATIENT	AGE	INCOME SOURCE (write in from list below)	MONTHLY AMOUNT

SOURCES OF INCOME: Social Security, Retirement Pension, Disability (Social Security or other), SSI, Food Stamps, TANF, Unemployment Benefits, Workers Compensation, Self-employed, Salary/Wages, Child Support and/or Alimony, Investment Income, All Other No Income
(Please be prepared to provide proof of these income sources)

C. MEDICATION INFORMATION

PLEASE LIST ALL KNOWN DRUG ALLERGIES: _____

Medication	Strength	How often taken	Other instructions	Prescribing doctor

PATIENT EXPECTATIONS: As long as I receive medication assistance as a patient of this program, I understand that:

1) prescriptions signed by my doctor will be **continue to be filled** for me. If my prescription is changed or stopped, I will **notify** this office.

2) I must **notify** this office when my **address or telephone number has changed** so that this office can tell me my medicine is available.

3) **FAILURE TO PICK UP MEDICINE.** If I **DO NOT** pick up the same medicine two times in a row, that medicine will not be reordered for me. If I **DO NOT** pick up any medicine three times, I will not longer receive medication assistance from this office.

4) a handling fee will be charged when I pick up my medicine from the pharmacy, unless I have been given a waiver of the fee.

5) Once each year, I must submit new proof of income information. If I do not submit annual proof of income, my prescriptions cannot be refilled.

MY SIGNATURE CERTIFIES:

- that the information I have given about the number of people in my household and all income received by them is complete and accurate. I will not hold MedAssist responsible should any of this information be found inaccurate.

- I give my permission for information on this form to be released to my physician(s)/providers and any pharmaceutical company that is being sought for donation.

- I give my permission for MedAssist caseworkers to sign any necessary forms on my behalf when ordering medications for me. My permission is valid as long as I am receiving services through the MedAssist program.

SIGNATURE: _____ DATE: _____

IF THE ABOVE SIGNATURE IS NOT THE PATIENT, PLEASE FILL IN INFORMATION BELOW:
NAME (PLEASE PRINT): _____ RELATIONSHIP TO PATIENT: _____
Power of Attorney? _____
ADDRESS: _____
PHONE #: (_____) _____
WITNESS: _____ DATE: _____