



MedAssist of MHC
HealthCONNECT
 43 W. Main Street
 Martinsville, VA 24112
 Telephone: 276-632-2246 * Fax: 276-632-4293

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 PROGRAM AT THIS TIME? 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 **continued to be filled** for me. If my prescription is changed or discontinued, I will **notify** this office immediately.
- 2) I must **notify** this office when my **address or telephone number has changed** so that this office and/or pharmacy can let know that 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 of \$5.00 per prescription 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: _____