SOUTHERN DOMINION HEALTH SYSTEM, Inc.

Pharmacy Assistance Program ● Patient Application Form

PERSONAL INFORMATION:

Name: _____ **SS#:** _____
(Last) (First) (MI)

Address: _____
(Street) (City) (ST) (Zip)

Phone: _____ _____ _____ _____
(Home) (Work) (Cell) (Alternate)

Sex: M / F **DOB:** ___ / ___ / ___ **Marital Status:** _____ **# in household** _____
(including yourself)

Name of Spouse: _____ **Spouse's SS#:** _____

INCOME INFORMATION: *Income from ALL MEMBERS of the household must be included.*

Employment: $_____ / month

TANF(Temporary Assistance for Needy Families): $_____ / month

Social Security/Disability: $_____ / month

Pension: $_____ / month

Alimony/Child Support: $_____ / month

Other: $_____/month

MEDICAL INSURANCE INFORMATION:

Circle appropriate answer:

1) **Do you have medical insurance through the Veterans Administration?** Y / N
2) **Do you have medical insurance through Medicare?** Y / N
3) **Do you have medical insurance through Medicaid?** Y / N
4) **Do you have medical insurance that covers prescriptions?** Y / N (Please Provide Copy of Card to MAC)
5) **Do you receive prescription assistance from any social service agency/clinic?** Y / N
6) **Have you applied for, and been denied, Medicaid coverage in the past year?** Y/N
7) **Are you currently enrolled in any of the drug companies' patient assistance programs?** Y / N
   - **If you circled YES to Question 7, please list the medication and company:**
     1) _____
     2) _____

I HEREBY STATE THAT THE INFORMATION ABOVE IS ACCURATE AND I GIVE PERMISSION FOR THE ABOVE INFORMATION TO BE RELEASED TO ANY PHARMACEUTICAL COMPANY WITH REGARDS TO REQUESTS FOR DONATED MEDICATIONS.

Signature of Applicant: _____ **Date:** _____

Referring Provider : _____**SDHS Location:**_____