# ALABAMA SENIOR Rx/WELLNESS CLIENT INTAKE FORM

Please complete and return to your Area Agency on Aging
Call **1-800-AGE-LINE (1-800-243-5463)** for the correct mailing

______________________
*AIMS CLIENT NUMBER (office use)*

Social Security #:_____________ Medicare#: _________________ County:_______________

Last Name:_____________________ First Name:_________________ MI:__________

Mailing Address:_____________________ Race: ___White: ___ African American:___ Other

Street Address:______________________ Birthdate: ____/____/____ Gender: ____ Male _____ Female

City/State/Zip: ______________________ Home Phone: (___) ____-_______ email: _______________________

How did you hear about our agency?______________________________________________________________

Employment Status: _____ Retired _____ Disabled _____ Full time _____ Part time

Are you a veteran or veteran's spouse/widow? Yes No
Number living in household (including client): ____________
Are you a person with a disability? Yes ___ No ____

Marital Status: ____ Married ____ Not Married ____Widowed Spouse's Birthdate: __ ____/_______/_____

Spouse's Name:_______________________________________ Spouse's Social Security#: _____________________

Primary Physician: ________________________________________________________________________
Name Address Phone

Emergency Contact: _______________________________________________________________________
Name Address Phone

**SOURCES OF INCOME**

(We MUST HAVE a copy of proofs of income for EVERYONE who lives in your household)

**TOTAL MONTHLY INCOME $_____________________ TOTAL ANNUAL INCOME $________________**

Salary/Wages $_____________ Unemployment $_____________ Social Security Disability $_____________
Veteran's Benefits $_____________ Child Support $_____________ Social Security $_____________
Workman's Comp $_____________ Pension $_____________ SSI $_____________
Railroad Retirement $_____________ Interest Income $_____________ Other $_____________

**Do you file federal taxes? Yes_____ No ____**

**(Attach copies of W2 forms, tax returns, bank statements, social security benefits statements, or other sources of income.)**

**Physician Information (names, phone numbers, and addresses of prescribing physicians):**

**1.**________________________________________________________________________________

**2.** ________________________________________________________________________________

**3.** ________________________________________________________________________________

**4.** ________________________________________________________________________________

**5.** ________________________________________________________________________________

The Alabama Department of Senior Services, through 13 Area Agencies on Aging, administers this statewide program. The information being collected will be kept STRICTLY CONFIDENTIAL.

## MEDICAL INFORMATION

Are you currently enrolled in another prescription assistance program or discount program? Yes____ No____

Are you enrolled in _____ Medicare _____ SLMB _____ QMB _____ QI-1

Medicare: A ______ B ______ C ______ D _______ Medicare Advantage Plan _____________________________

Are you currently paying 100% for your prescription medications? Yes_____ No_____

Are you currently in your Medicare Part D Coverage Gap? Yes_____ No ____ Plan Name _______________________

| Medication | Directions/Strengths | Name of Prescribing Doctor | Pharmaceutical Company | Cost Per Month |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
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| 9. | | | | |
| 10. | | | | |

I am interested in Prescription Assistance only. Yes ___ No___/ I am interest in Prescription/Wellness Yes ___No___

Medical Conditions: (please circle) Heart Asthma High BP Ulcer Glaucoma

Other: ______________________________________________________________

Medication Allergies: (please circle) None Sulfa Penicillin Aspirin Codeine Iodine

Other: ______________________________________________________________

I hereby state that the information I have given is correct to the best of my knowledge and the **ALABAMA SENIOR Rx** Program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand the **ALABAMA SENIOR Rx** Program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services.

Signature: ____________________________________________ Date:_____________

| Medication | Directions/Strengths | Name of Prescribing Doctor | Pharmaceutical Company | Cost Per Month |
|---|---|---|---|---|
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