PROGRAM APPLICATION

Prescription Assistance Program

www.prescriptionassist.org

LAST NAME:	**FIRST NAME:**	**MI:**
DATE OF BIRTH:	**SOCIAL SECURITY #:**	
HOME PHONE #:	**CELL PHONE #:**	
ADDRESS: (Please no post office box numbers)	**CITY:** **STATE:**	**ZIP CODE:**
U.S. CITIZEN? Y N	**U.S. RESIDENT?** Y N	**DISABLED?** Y N
RACE / ETHNICITY:	**GENDER:** M F	**MARITAL STATUS:** M W D S
EMPLOYMENT STATUS: Full Part Retired Not in Labor Force Unemployed		
OCCUPATION:	**EMPLOYER:**	

PLEASE LIST ANY ADDITIONAL INDIVIDUALS THAT RESIDE IN HOUSEHOLD

NAME:	**DATE OF BIRTH:**
NAME:	**DATE OF BIRTH:**
NAME:	**DATE OF BIRTH:**
NAME:	**DATE OF BIRTH:**

APPLICANT INSURANCE INFORMATION

MEDICARE: Y N	**MEDICAID:** Y N	**VETERANS BENEFITS:** Y N
MEDICARE PART D: Y N	**CARRIER:**	**ID#:**
PRIVATE INSURANCE: Y N	**CARRIER:**	**ID#:**
DOES YOUR PRIVATE INSURANCE HAVE PRESCRIPTION COVERAGE? Y N		

APPLICANT PHYSICIAN INFORMATION

PRIMARY PHYSICIAN:	**PROVIDER:**	**TELEPHONE #:**
PRIMARY PHYSICIAN ADDRESS:		
SECONDARY PHYSICIAN:	**PROVIDER:**	**TELEPHONE #:**
SECONDARY PHYSICIAN ADDRESS:		
PLEASE LIST ANY DRUG ALLERGIES:		

Prescription Assistance Program

www.prescriptionassist.org

HOUSEHOLD FINANCIAL INFORMATION

MONTHLY HOUSEHOLD INCOME	
WAGES	$
SOCIAL SECURITY	$
SSI	$
SSDI	$
OTHER DISABILITY	$
UNEMPLOYMENT	$
PENSION	$
OTHER	$
TOTAL INCOME	**$**
TOTAL ASSETS (PLEASE INCLUDE ALL SAVINGS, CHECKING, IRA, ANNUITIES, STOCKS, BONDS, CDS)	**$**
CURRENT RESIDENCE:	Rent or Own

I attest that the above information is correct to the best of my knowledge. I am fully aware that if I fail to accurately report information about my age, income, and family size which would disqualify me, I may be dropped from the program. I agree to provide South Central Adult Services Council Inc. with documentation to substantiate my eligibility upon their request. I further agree that I will report promptly to South Central Adult Services Council Inc. any changes in circumstances. My signature authorizes Prescription Assistance Program staff to act on my behalf and disclose information regarding my financial status and medication needs with my doctor and the pharmaceutical company providing medications for the purpose of assisting me with my medication needs. This authorization is voluntary and remains in effect until specifically revoked by written notice to the agency or person signing this authorization.

APPLICANT SIGNATURE:	**DATE:**
LEGAL GUARDIAN / REPRESENTATIVE SIGNATURE:	**DATE:**

PLEASE INCLUDE THE FOLLOWING ATTACHMENTS TO COMPLETE APPLICATION

___ List of medications which indicates prescribing doctor and dosage
___ Copy of most recent income tax return 1040 form (first two pages only) or 4506 form if you do not file income tax.
___ Copy of proof of income from any additional sources not covered by tax form (ex: social security statement, unemployment statement, etc.).
___ Copy of photo ID, social security, or green card.
___ Copy of health insurance cards
___ Printout showing current year medication expenses (Medicare Part D clients only)

Prescription Assistance Program
139 2nd Avenue Southeast
Valley City, ND 58072
800-472-0031
papvc@southcentralseniors.org