

**MOUNT ROGERS MEDICATION ASSISTANCE PROGRAM  
THROUGH THE BLAND COUNTY MEDICAL CLINIC**

**APPLICATION FORM (7 SECTIONS)**

**1. YOUR HEALTHCARE PROVIDER IS:** (circle one - this is required)

Dr. M. Crews    Pat Mitchell, FNP    Elaine Harper, ANP    Jill Snider, FNP    Dr. H. Sathre  
Debbie Croy, ANP    Mary Jo Collie, FNP    Nancy Davidson, FNP    Carolyn King, FNP

**2. PERSONAL INFORMATION:**

YOUR NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
COUNTY: \_\_\_\_\_ PHONE: \_\_\_\_\_  
GENDER: (circle) Male Female    BIRTH DATE: \_\_\_\_\_  
MARITAL STATUS: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_  
RACE (optional): \_\_\_\_\_ TOTAL IN HOUSEHOLD: \_\_\_\_\_ (including yourself)

**3. INCOME:**

Please fill in monthly amount received beside correct source(s) of income, be sure to include amounts for each person in the household. If income is received from employment we will need copy of tax return, Form 1040 (not W-2's) from most recent year as well as documentation of all other income. **\*If you currently have no income you must provide letters of documentation showing how you are currently supporting yourself (paying bills, rent, buying food, etc.)\***

**\*\*YOUR APPLICATION WILL NOT BE PROCESSED WITHOUT PROOF OF INCOME ATTACHED TO IT\*\***

**Did you file taxes for 2008?    Yes    No**

**\*\*Please return a copy of your 2008 tax FORM 1040\*\*** (see attached example of the form we need, we cannot use any other form. You must return a copy of this form even if your income has changed)

**Employment:**

You \$ \_\_\_\_\_ /month                      Others \$ \_\_\_\_\_ /month

**Social Security:**

You \$ \_\_\_\_\_ /month                      Others \$ \_\_\_\_\_ / month  
You \$ \_\_\_\_\_ / month                      Others \$ \_\_\_\_\_ / month

**Retirement/Pension:**

You \$ \_\_\_\_\_ /month                      Others \$ \_\_\_\_\_ / month

**Alimony/child support:**

You \$ \_\_\_\_\_ /month                      Others \$ \_\_\_\_\_ /month

**Other (please specify):**

You \$ \_\_\_\_\_ / month                      Others \$ \_\_\_\_\_ /month

**\*\*\* For social security and disability we need the benefit amount letter from Social Security stating what the monthly amount is for 2009\*\*\***

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**4. INSURANCE COVERAGE:** (You must circle one)

Medicare                      Medicare supplement  
Medicaid                      Veteran Benefits                      None-Uninsured  
Other (please specify): \_\_\_\_\_

Do any of these policies cover prescription drugs?    YES    NO

**5. DRUG ALLERGIES:**  
(Please list any drug allergies you may have, if none please write “none”)

\_\_\_\_\_

**6. CURRENT MEDICATIONS:**

Name of drug	Dosage/Strength	How often medicine is taken (once a day, twice a day, etc)
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

\*IF ADDITIONAL SPACE IS NEEDED PLEASE USE SEPARATE SHEET\*

**7. PLEASE READ AND SIGN BELOW:**

I certify by my signature below that I am not covered under any prescription plan, that the information I have provided is true and correct and that the agent of the Medication Assistance Program can verify the above information using the necessary means.

Signature \_\_\_\_\_  
Date: \_\_\_\_\_