

**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. Crews Pat Mitchell, FNP Elaine Harper, ANP Jill Snider, FNP Dr. Sathre
Debbie Croy, ANP Mary Jo Collie, FNP Mary Martin, ANP Nancy Davidson, 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 2007? Yes No

****Please return a copy of your 2007 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 2008*****

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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: _____