



# MEDICATION ASSISTANCE PROGRAM

515 West 6<sup>th</sup> Street Jacksonville, FL 32206 (904) 632-5397



## PATIENT APPLICATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Martial Status: \_\_\_\_\_

Gender: Male  Female  US Citizen: Yes  No  Veteran: Yes  No

Employment Status: Full-time  Part-time  Retired  Unemployed

Do you have insurance that pays for all or part of prescription medication: Yes  No

(Medicaid, Medicare, Private Insurance, VA benefits, state or local programs)

### Prescription Medications

Drug Name	Strength	Directions	Doctor

Current Monthly Prescription Costs: \_\_\_\_\_

### Healthcare Provider – list your provider/doctor(s) information below

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Income - List Monthly Household Income Below – Proof of all sources must be attached, see back

Salary/Wages: \_\_\_\_\_

SS Retirement: \_\_\_\_\_

Interest/Annuity/IRA: \_\_\_\_\_

Unemployment: \_\_\_\_\_

SS Disability: \_\_\_\_\_

Child Support: \_\_\_\_\_

Alimony: \_\_\_\_\_

Pension Retirement: \_\_\_\_\_

Other: \_\_\_\_\_

**(PLEASE COMPLETE BACK OF APPLICATION)**

**Insurance Benefits (Check all that Apply)**

- Private Insurance        Medicare Supplement        Other: \_\_\_\_\_
- Medicaid                Uninsured
- Medicare                Florida Kid Care

**COPIES OF INCOME VERIFICATION MUST BE SENT WITH THE APPLICATION**

**(Note: Income verification documentation must be your most recent copy)**

- 1. Are you currently employed?                      Yes  No     If yes, include a copy of your (W-2) form
- 2. Were you employed last year?                      Yes  No     If yes, include a copy of your Federal Income Tax Return
- 3. Are you unemployed?                                  Yes  No     If yes, include a copy of Unemployment Check Statement
- 4. Are you retired?                                        Yes  No     If, yes include a copy of Social Security Benefit Verification Statement (SSA 1099) & your most recent tax return
- 5. Do you receive disability?                            Yes  No     If yes, include a copy of your Disability Check Verification Statement
- 6. Do you have a Pension or Retirement Plan?                      Yes  No     If yes, include a copy of your Dividend & Distributions Statement (1099-DIV)
- 7. Do you receive interest from an interest bearing account?                      Yes  No     If yes, include a copy of your most recent Income Interest Statement (1099-INT)
- 8. Do you receive alimony or child support?                      Yes  No     If yes, include copies of checks
- 9. Do you receive income from rental property?                      Yes  No     If yes, include copies of checks
- 10. Do you have an medical insurance card?                      Yes  No     If yes, please provide a copy of the front and back

I authorize the employees of the Duval County Health Department Medication Assistance Program (MAP) to act on my behalf and sign forms on my behalf and related applications for medication assistance by giving limited power of attorney for this specific purpose only. I understand that authorization can be revoked at any time by me by providing written notification of revocation to the Medication Assistance Program.

I authorize my physician/provider’s office to discuss/release medical information to the Medication Assistance Program relating to my application for medication assistance. I understand that this authorization will be valid until a written revocation of this authorization is received.

I understand that the MAP program does not prescribe, purchase, sell or dispense prescription medication of any kind. I also understand that each pharmaceutical company makes the final decision as to weather I qualify for their prescription assistance program and enrollment in the Medication Assistance Program does not guarantee medication will be received.

I understand that the application process may take up to eight weeks to approve. The MAP program is not responsible for any adverse health consequences that may result due to a decision to delay taking medication while waiting on program approval.

**Signature:** \_\_\_\_\_  
Applicant Signature

**Date:** \_\_\_\_\_

**If you require assistance in completing this application or have questions regarding the program, please call (904) 632-5397**

