

# Regional Healthcare Foundation

## Prescription Drug Assistance Program

215 W. Grant Street , Dexter, MO 63841

Phone: 573-624-1607 ♦ Fax: 573-614-4908

**THE FOUNDATION'S PRESCRIPTION DRUG ASSISTANCE PROGRAM IS NOT A SUBSTITUTE FOR AND IS NOT ASSOCIATED WITH THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM. IF YOU ARE ELIGIBLE FOR PART D AND YOU DO NOT ENROLL IN THAT PROGRAM WITHIN THE TIME REQUIRED, YOU MAY HAVE TO PAY A HIGHER PREMIUM, IF YOU LATER ENROLL IN PART D.**

**PATIENT INFORMATION FORM MUST BE COMPLETED ENTIRELY**

Today's Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

**PATIENT INFORMATION** (Please PRINT all information)

First Name: \_\_\_\_\_ M \_\_\_\_\_ Last \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work \_\_\_\_\_ Message \_\_\_\_\_

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

Street or County Road Address: \_\_\_\_\_

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

**PERSONAL INFORMATION**

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Circle One: Male or Female

US Citizen Yes No US Resident Yes No US Veteran Yes No

Marital Status: Circle One

Single Married Divorced Widow Other \_\_\_\_\_

Employment Status: Circle One

Employed Self-employed Unemployed Retired Other \_\_\_\_\_

Race (Optional) \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Number in Household (including patient) \_\_\_\_\_ Number of children in household under the age of 18 \_\_\_\_\_

Did you file Income Taxes for 2009? \_\_\_Yes \_\_\_No

**INSURANCE INFORMATION** Circle either Yes or No

Do you have ANY prescription drug coverage? Yes No

Amount of monthly out of pocket medical expenses: \_\_\_\_\_  
(Prescription or over-the-counter medication costs, hospital or physicians bills, etc. includes anything actually paid out of the patients pocket)

Do you have Medicare? Yes No Medicare Claim # \_\_\_\_\_

If yes, have you applied for Low Income Subsidy (LIS) from Social Security? Yes No

Have you enrolled in Medicare Part D? Yes No Do you have a Medicare Supplement? Yes No

Company Name & Policy # of Supplement: \_\_\_\_\_

Do you have Medicaid? Yes No If yes, does it cover ANY prescriptions? Yes No

Do you have a spend down? Yes No

Have you applied for Medicaid (in the last 2 years) and have been denied? Yes No  
(If yes please send a copy of the denial letters)

Are you legally disabled? Yes No What date were you declared legally disabled? \_\_\_\_\_