Free Pharmacy Application
Alleghany Cares Inc.

RENEWAL _____

NEW _____

CLIENT NAME_____

Mailing Address_____ **Phone**_____

City_____**, NC Zip**_____ **County**_____

Emergency Contact:_____ **Phone**_____

Household Information

	Name	DOB	Sex	Social Security	Ethnicity White,Black Asian, Hispanic	Employed Yes/No	Disabled Yes/No	Relationship to Client	
Applicant									
Spouse									
Child									
Child									
Child									
Other									
Other									

PRESCRIPTION INSURANCE

Do you have private or employer prescription insurance?

Do you have Medicaid? (Circle One) Yes/No Children Only – Yes/NoSpend down amount $_____

Are you a Veteran? Yes/No Are you receiving medicine benefits? Yes/No

Have you recently applied for Disability? Yes/No Medicaid? Yes/No

Do you have Medicare Part A Yes/No Prescriptions Yes/No

Part B Yes/No Prescription Yes/ No Part D Yes/ No Prescription Yes/No

Do you have Prescription Card for any other insurance? Yes/No Company name_____

Community Services & Additional Information

Do you receive Food Stamps? Yes/No If yes , $_____

WIC Yes/No

HUD housing Yes/No

Are you a single parent Yes/No

Current Gross Monthly Household Income

		Applicant	Spouse	Other member
1	Work (Salary + Cash payments)			
2	Rental Income			
3	Work First			
4	Alimony			
5	Child Support			
6	Unemployment Compensation			
7	Social Security			
8	SSI			
9	VA Benefits			
10	Pension Payments			
11	Annuity Payments			
12	Investment (Dividends, Interest, CDs, IRAs			

200% of Federal Poverty Level for household size: $ _____Total Household Income: $_____

If you listed income on line 12, please list individually

Asset	Value

Total $_____$_____

Please List any additional assets. Assets include land other than your home, checking accounts, savings accounts, Money Market accounts, stocks, mutual funds, CDs or retirement accounts.

Asset	Value

Total $_____$_____

Do you anticipate significant changes in Household Income or Assets? Yes/No

If yes, Please explain: _____

Patient Information

Primary Care Physician _____

Drug Allergies

_____Penicillin _____Aspirin
_____Sulfa _____Other_____
_____Codeine _____Other_____
_____Erythromycin _____Other_____

Medication you are currently taking

1_____ 4_____
2_____ 5_____
3_____ 6_____

Current Medical Conditions

_____Asthma _____Arthritis
_____Cancer _____Bronchitis
_____Diabetes _____Heart Disease
_____High Blood Pressure _____Other_____

Do **you need Child Resistant Packaging?** Yes/No (circle one) Client/Guardian

Disclosure Permission

I hereby permit the Alleghany Cares Inc. staff to contact any person or agency to discuss issues surrounding my application for assistance. I also verify that the information given above is truthful and that I have not made any attempts to misrepresent my need for assistance. I agree to report any change in income or insurance immediately and understand that failing to do so may result in being ineligible for future assistance through the program.

Client Signature: _____ Date_____

Staff Signature:_____Date_____

Reevaluation recommended in ____3 months ____ 6 months _____12 months

Alleghany C.A.R.E.S. Medication Assistance Program

P. O. Box 1655, **Phone 336.372.5559**
25 Womble Street, Sparta, NC 28675 **FAX 336.372.6808**
Email:CaresMAP@skybest.com

How our program works:

YOU:

1. Complete an application and provide proof of household income, proof of residency (a utility bill or bank statement with your current name and address), and a valid North Carolina driver's license or North Carolina state-issued I.D. card.
2. Provide a valid prescription and receive a pick-up slip.
3. On the following day, exchange the pick-up slip for your medication at Halsey Drug.

MAP:

We will pay for a maximum of three monthly prescriptions per client. If the cost of a medication is not covered through our program, we will advise you of any other possible sources for assistance and help you complete applications for those programs.

By participating in the Medication Assistance Program, I understand & agree to the following:

I am responsible for bringing in a valid prescription or refill at least **one day in advance** of needing my medications. I understand that pick-up slips will only be given for a valid prescription presented directly in person to MAP.

I am responsible for contacting my doctor directly if I need a new prescription.

I understand that my medications will not be ready for pick-up until the day after I give my prescription or refill to MAP. I understand that contacting Halsey Drug to ask for exceptions to this policy will result in being dropped from participation in the Medication Assistance Program.

I agree to pick up my medications at Halsey Drug within five days of the date on my pick-up slip.

I will immediately notify the Medication Assistance Program of any changes in address, phone number, household income or insurance. I understand that failing to do so may result in being removed from the program and dropped from future participation.

Signature_____ Date_____