RxRelief Program ● Patient Information Form

Personal Information:

Name: ____ **SS#:** ______________________
(Last) (First) (MI)

Address: ____
(Street) (City) (State) (Zip)

Phone: _____________ _______________ ______________
(Home) (Work) (Cell)

Sex: M / F **DOB:** ___ / ___ /____ **Marital Status:** _________ **# in household** ________
(including yourself)

Ethnicity: _____________________________ (optional)

Name of Spouse: ________________________ **Spouse's SS#:** ______________________

Income Information: *Income from ALL MEMBERS of the household must be included.*

Employment: $________/month **TANF:** $________/month

Social Security/Disability: $________/month **Pension:** $________/month

Spousal/Child Support: $________/month **Other:** $________/month **Source:** ___________

Medical Insurance Information:

1. **Did you file a tax return for the previous year?** Y / N
2. **Do you have Medicaid or Medicare Part A, B or D? If yes, circle one** Y / N
3. **Do you have medical insurance that covers prescriptions?** Y / N
4. **Do you receive prescription assistance from any social service agency/clinic?** Y / N
5. **Are you currently enrolled in any drug companies' patient assistance program?** Y / N
   - **If you circled YES to question 5, please list the medication and company:**

     1. ____
     2. ____

I HEREBY STATE THAT THE ABOVE IS ACCURATE AND I GIVE PERMISSION FOR THE ABOVE INFORMATION TO BE RELEASED TO ANY PHARMACEUTICAL COMPANY WITH REGARDS TO REQUESTS FOR DONATED MEDICATIONS.

Signature of Applicant: ______________________________ **Date:** _______________

Please fax to Helen Frye, United Way - Thomas Jefferson Area: (434) 972-1719