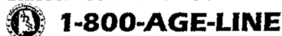
Want Free Prescription Drugs?

Lee-Russell Council of Governments



ARE YOU AT LEAST 55 YEARS OF AGE?

DO YOU NEED HELP GETTING PRESCRIPTION MEDICATIONS?

SenioR$_x$ can help with the high cost of prescription drugs. It strives to reduce economic stress, promote better health and improve the quality of life of Alabama's older population by providing ways to reduce the expense of life sustaining medications.

SenioR$_x$ is a partnership of state agencies and community organizations that assists seniors with **applying for drug assistance programs** provided by pharmaceutical manufacturers.

You are eligible if:

- ☑ **You are at least 55 years of age.**
- ☑ **You have NO prescription drug coverage.**
- ☑ **You have a chronic medical condition.**
- ☑ **You are disabled in the 24 month gap for Medicare**
- ☑ **You are in the Medicare Part D "Gap" coverage**
- ☑ **You are a legal resident of the state of Alabama**

SENIOR$_x$

Partnership for Medication Access

1-800-AGE-LINE (243-5463)

www.AGELINE.net

334 749-5264 Lee-Russell Council of Governments

ALABAMA

Administered statewide by the Department of Senior Services
through 13 Area Agencies on Aging that provide
a variety of services for all Alabamians over the age of 55

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PRESCRIPTION DRUG
Assistance For
Individual Citizens 55 and older

APPLICATION INSTRUCTIONS

Thank you for allowing us to help you with your medication needs. We hope this service will be of great benefit to you. We look forward to working with you. Please carefully follow all directions on the application and include all information needed .After completing the application, **MAIL THE APPLICATION BACK TO US:** along with the following information listed below. This will help us to serve you in a more efficient manner. Failure to do so may delay the process.

PLEASE ATTACH COPIES AND MAIL IN COPIES OF THE FOLLOWING DOCUMENTS WITH YOUR APPLICATION:

1. A COPY OF YOUR Social Security Card and Photo ID, Drivers License.
2. Proof of income for EVERYONE who lives in your household.
3. Proof of any other income such as: Annuities, Stocks, Bonds, CD's, IRA's, Savings Accounts, Interest Income.
4. A list of your present medications from you pharmacies, including dosage information and cost per prescription. Please clearly list all medications you are requesting help with on the application or attach the pharmacy print out.

For more information, contact:
Lee-Russell Council Area Agency on Aging
SeniorRx Prescription Medication Program
(334)749-5264 Ext. 247 or Ext. 250

Administered statewide by the Department of Senior Services through 13 Area Agencies on Aging that provide a variety of services for all Alabamians over the age of 55.

This information will be kept **STRICKLY CONFIDENTIAL** and will expedite the application process.

Mail To:
Lee-Russell Council Area Agency on Aging
2207 Gateway Drive
Opelika, Alabama 36801
Attention: Deborah Yount or Jean Causey

ALABAMA SENIOR Rx

CLIENT INTAKE FORM

Please complete and return to your Area Agency on Aging.
Call **1-800-AGE-LINE (1-800-243-5463)** for the correct mailing address.

____
AIMS CLIENT NUMBER (office use)

Social Security #: ______________ Medicare #: ______________ County: ______________

Last Name: ______________ First Name: ______________ MI: ______

Mailing Address: ______________ Race/Ethnicity: ___ White ___ African American ___ Other

Street Address: ______________ Birthdate: _____/_____/_____ Gender: ___ Male ___ Female

City/Zip: ______________ Home Phone: (   )   -

Did you file income taxes last year? Yes No

Are you a legal resident of the U.S.? Yes No

Employment Status: ___ Retired ___ Disabled ___ Full time ___ Part time

Are you a veteran or veteran's spouse/widow? Yes No

Number living in household (including client): ________

Marital Status: ___ Married ___ Not Married ___ Widowed

Spouse's Birthdate: _____/_____/_____

Spouse's Name: ______________ Spouse's Social Security #: ______________

Primary Physician: ______________________________
Name Address Phone

Emergency Contact: ______________________________
(Not living with you) Name Phone Relationship

SOURCES OF INCOME

(We MUST HAVE a copy of proofs of income for EVERYONE who lives in your household.)

TOTAL MONTHLY INCOME $ ______________ **TOTAL ANNUAL INCOME $** ______________

Salary/Wages $ ________ Unemployment $ ________ Social Security Disability $ ________
Veteran's Benefits $ ________ Child Support $ ________ Social Security $ ________
Workman's Comp $ ________ Pension $ ________ SSI $ ________
Railroad Retirement $ ________ Interest Income $ ________ Other $ ________

(Attach copies of W2 forms, tax returns, bank statements, social security benefits statements, or other sources of income.)

TOTAL AMOUNT OF ASSETS $ ______________
For example: any bank accounts, investments, 401K, property you own (other than the house you live in)

TOTAL AMOUNT OF EXPENSES $ ______________
For example: mortgage or rent, utilities, insurance (not health insurance)

TOTAL MEDICAL EXPENSES $ ______________
(For example: Over-the-counter medicines, health insurance,premiums, copays, medical supplies, doctor & hospital visits, lab fees)

PRESCRIPTION DRUG COSTS $ ______________
(a monthly average)

The Alabama Department of Senior Services, through 13 Area Agencies on Aging, administers this statewide program.
The information being collected will be kept STRICTLY CONFIDENTIAL

MEDICAL INFORMATION

Are you currently enrolled in another prescription assistance program or discount program? _____ Yes _____ No

Are you enrolled in _____ Medicare _____ VA Benefits _____ SLMB _____ QMB _____ QI-1

Do you have any health insurance coverage? ______________________________
(other than Medicare) Company Policy #

Do you have a Medicare Supplemental Policy? ______________________________
Company Policy #

***If you have more than one prescribing physician, please attach a list with each doctor's name, address and telephone number. ALABAMA SENIOR RX cannot guarantee that you will receive the medicines requested.**

Medication	Directions/ Strength	Name, phone number and address of prescribing doctor	Cost per Month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical Conditions: (please circle) Heart Asthma High BP Ulcer Glaucoma

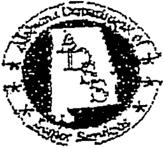
Other: ______________________________

Medication Allergies: (please circle) None Sulfa Penicillin Aspirin Codeine Iodine

Other: ______________________________

I hereby state that the information I have given is correct to the best of my knowledge and the ALABAMA SENIOR RX Program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand the ALABAMA SENIOR RX Program cannot guarantee assistance. I understand that omitting or falsifying informtaion is grounds for denial of services.

Signature: ______________________ Date: ______________



ALABAMA SENIORx
Partnership for Medication Access
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PATIENT CONSENT AND RELEASE FORM

I give permission to authorized representatives of the Alabama **SenioRx** to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize **SenioRx** to discuss my medical needs and me with my physician when necessary. Additionally, I give **SenioRx** permission to verify my income through the Department of Human Resources, Social Security Administration, my employer, Veterans Administration or any other company, business or organization form which I receive income. This authorization is good as long as **SenioRx** is assisting me or until I revoke such.

I want a copy of this form to be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

DOB:__________________ SSN:______________________________

ADDRESS:____

FULL PRINTED NAME OF PATIENT:______________________________________

SIGNATURE:_____________________________ DATE: _____________________

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of SenioRx Foundation to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization good as long as SenioRx is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: ____________________________________

SIGNATURE: _________________________________ DATE: _________________