Alabama Department of Senior Services
SenioRx
FY24 Participant Enrollment Form

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

PARTICIPANT INFORMATION: **Shaded area required for ADSS. Other information as required by medication assistance programs.**		
Last Name:	First Name:	MI:
Street Address:	Mailing Address (If different):	
City: State: Zip:	City: State: Zip:	
County:	Home Phone: ( ) Other Phone: ( )	
Email address:		
Birthdate: ____/____/_____ MM DD YYYY	Gender: ☐ Male ☐ Female	
Race: ☐ Caucasian/White ☐ Asian ☐ African-American/Black ☐ Native Hawaiian ☐ Alaska Native ☐ Pacific Islander ☐ American Indian ☐ Other	**Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino	
Do you live alone? ☐ Yes ☐ No	☐ **Dementia-related diagnosis**	
Income Range: Is your gross monthly income above $1,215 ☐ Yes ☐ No		
EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.		
Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____	Relationship to participant: ☐ Spouse ☐ Other Relative ☐ Friend ☐ Neighbor	
Primary Physician:	Physician Phone:	
Social Security #:	Medicare #:	
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 #: _____-_____-_____	

SOURCES OF INCOME

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

TOTAL MONTHLY INCOME $_____ TOTAL ANNUAL INCOME $_____

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

Attach copies of W2 form(s), tax return(s), bank statement(s), Social Security benefit statement(s), or other sources of income

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 #

Medical Conditions: (Check all that apply)	☐ Heart	☐ Asthma/COPD	☐ B/P	☐ Gastrointestinal
	☐ Cholesterol	☐ Dementia	☐ Mental Health	☐ Glaucoma
Medication Allergies: (Check all that apply)	☐ None	☐ Sulfa	☐ Penicillin	☐ Codeine
	☐ Iodine	☐ Other	☐ Aspirin	

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

Medication	Dosage	Name, Phone Number, and Address of Prescribing Doctor	Cost per month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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

Signature: _____ Date: _____

Statement of Confidentiality: The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.