MEDICATION ASSISTANCE PROGRAM (MAP)

Application Packet

This packet of information and forms will help you apply for financial assistance from your local medication assistance program. It is important that you fill this paperwork out completely and have the proper documents to turn in for consideration. If you have questions, you may contact your local representative at the numbers below. MAP is not affiliated with the eligibility assistance program. Thank you.

Checklist for Applying for Medication Assistance

- ☐ Complete the MAP application. (see attached)
- ☐ Provide specific income documentation. Refer to pages 3 & 4 of application for details.
- ☐ Provide a copy of a valid Photo ID (Examples include: current driver's license or ID issued by DMV)
- ☐ If you have Medicare Part D (prescription coverage), you will need to provide the following:
  - ☐ A copy of the front and back of the Medicare Part D (prescription coverage) card and Medicare card.
  - ☐ A copy of Explanation of Benefits (EOB) that details out of pocket prescription expenses for the current calendar year . Get this from your insurance company. You can also provide a print-out form from your local pharmacy (dated1-1 current year until present date).
  - ☐ If you have a Low Income Subsidy (LIS) denial letter, please attach a copy with your application.

Please return your completed MAP application to your local MAP office by mail, or deliver it in person (see page one of application for addresses). You may also return it to your prescriber's office for processing. Don't forget to keep a copy of this packet for your records.

Contact us at any of these offices if you have any questions.

CMAP (Roanoke) 540-981-7647

NRVMAP (Radford) 540-731-2414

GMAP (Giles) 540-922-4282

Referred by: _____

CARILION CLINIC

These programs are supported by Carilion Clinic, but applications are approved by other agencies.

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Please fill out this application completely and mail it to the location nearest your home. You may also fax it (if a number is supplied) or deliver it in person (best to call ahead for office hours).

Giles Medication Assistance
159 Hartley Way
Pearisburg, VA 24134
Phone: 540-922-4282
1-866-630-GMAP (4627)
540-921-1824 (FAX)

Carilion Medication Assistance
1906 Belleview Ave. (Ground FL)
Roanoke VA 24014
Phone: 540-981-7647
540-344-0301 (FAX)

NRV Medication Assistance
P.O. Box 5
Radford, VA 24143
Phone: 540-731-2414
540-731-2413 (FAX)

Date _____ Email Address _____

Name _____
(First) (Middle) (Last)

Social Security # _____-_____-_____ Date of Birth _____
MM DD YYYY

(CIRCLE ONE)

GENDER	Female	Male				
ETHNICITY	African/ American	Asian	Caucasian	Hispanic	Native American	Other
MARITAL STATUS	Single	Married	Separated	Divorced	Widowed	
U.S. CITIZEN?	Yes	No				

Mailing address:

Street Address/P.O. Box _____

City _____County _____State _____ Zip _____

Physical address (if different from above):

Street Address _____

City _____County _____State _____ Zip _____

Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Circle your answer:

- Is English your first language? YES or NO
- If NO, please list first language _____
- Are you a U.S. Military Veteran? YES or NO

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- Employment Status (circle one): Employed Unemployed (short term) Unemployed (long term) Self-employed Retired Student Disabled
- Are you legally disabled (receive a Social Security disability check)? YES or NO
- If YES, since what date: _____-_____-_____
- Who is your family medicine physician? _____ Phone_____
- Do you have insurance that provides prescription drug coverage? YES or NO
- If YES, please list the name of your insurance company _____
- Do you receive any services from Blue Ridge Behavioral Healthcare? YES or NO

Please list your mediations, dosage, the reason for taking the medication, and the prescriber.

Medication/Strength	Dosage (How often do you take it)	Reason for taking (diagnosis)	Prescriber (Health care provider)

List Medication Allergies : _____

_____

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Patient Name:			DOB:
	Adults	**Children under 18 Years Old**	**Total**
Number of People In Your Household			

Use the chart below to list every member of your household. Include income from **ALL** sources including: wages, Social Security, disability, retirement, pension, Veteran's benefits, child support, self-employment, interest, dividends, etc.

Name of Household Member	Age	Type of Income	Gross Amount	How often do you receive this income?
Patient:				

Income Documentation

Did you file a Federal Income Tax Return for last year? YES or NO (circle one)

If YES, provide a copy of your Federal Income Tax Return for yourself and your spouse if married or if you are claimed on someone's taxes. If self-employed, include Schedule C.

If NO, complete Tax Form 4506-T (attached at the end of this application), to verify that you did not file a Federal Income Tax Return. If you are married and your spouse did not file a Federal Income Tax Return, your spouse needs to complete the spouse's portion of the form.

Do you, your spouse or any of your dependents (under the age of 18) receive Social Security benefits? YES or NO (circle one)

If YES, provide a copy of your Current Benefit Verification Statement. Please note that copies of your bank statement are **not** acceptable. If you need to obtain a copy of your Current Benefit Verification Statement, you may visit your local Social Security office or call 800-772-1213.

Do you or anyone in your household receive any other type of income not listed above? YES or NO (circle one)

If YES, provide documentations. Bank statement cannot be accepted (i.e. 1099, etc).

If you are receiving support from a family member or other individual or If you do not have a household income, complete the attached form (Zero Income Statement) on page 9.

Please note that MAP may not obtain any medications on your behalf if the correct income documentation is not provided. If you have any questions about what type of documentation is required, contact any of the listed MAP offices.

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Patient Name:	DOB:

Asset Information

Complete the table below:

Assets	Total $ Value	Monthly Interest/Earnings
Checking/Savings	$	$
Stocks/Bonds/CDs	$	$
IRA	$	$
Annuities	$	$
Other	$	$
Total	$	$

Insurance

Mark in the appropriate column below to indicate if you have any of the following types of coverage:

TYPE	YES	NO
Medicare Part A		
Medicare Part B		
Medicare Part D		
Medicaid QMB Extended (with Prescription Drug Coverage)		
Medicaid (Spend Down)		
Veteran's Assistance		

If you have Medicare, please answer the following questions:

1. Do you have Medicare part D prescription drug coverage? YES or NO
2. Have you applied for the Low Income Subsidy, also known as Extra Help, to help with the cost of a Medicare Part D prescription drug plan? YES or NO
3. Would you like additional information about Medicare Part D and the Extra Help that may be available to you? YES or NO

Are you currently using drug manufacturer medication assistance programs? YES or NO

If YES, what drug companies do you work with _____

If YES, what drugs do you get from these programs? _____

What retail pharmacy do you use to buy your medications?

_____

MEDICATION ASSISTANCE PROGRAM (MAP)

Patient Name:	DOB:

Medication Assistance Program
Signature Waiver

I authorize designated representatives of the Carilion Medication Assistance Program to sign my name on the necessary pharmaceutical forms that may be required for ordering my needed medications. This could also include form 4506-T (verification of non-filing of a Federal Income Tax return with the IRS). The purpose is to expedite the ordering process by eliminating having to mail forms to the patient for signatures.

Patient Signature: _____

Date of Signature: _____-_____-_____

HIPAA Privacy / Confidentiality Permission Form

One of the goals of the Medication Assistance Programs (MAPs) is to provide you with medication while maintaining your confidentiality. Please list family members or individuals who may discuss your medication needs with MAP representatives.
MAP representatives will only discuss medication needs with the individuals listed below.

If this information changes while you are enrolled in the MAP, notify our program.

Name	Relationship	Telephone Number

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Patient Assistance Program Consent

I authorize Carilion Clinic and any Carilion Medication Assistance Advocate ("Carilion") to request free or reduced rate pharmaceuticals for use in my treatment from patient assistance programs of pharmaceutical companies. I authorize Carilion to fill in and sign application forms using information supplied by me.

I authorize Carilion, the pharmaceutical companies and any insurer, employer, or healthcare provider to disclose to any pharmaceutical company and to each other, all of my medical records and information, financial and insurance records and information, and other personal identifying information, necessary for my enrollment or participation in a patient assistance program. I verify that the information provided to Carilion is complete and accurate. I grant the companies the right to investigate all claims made on my behalf and agree to notify them of any change in my insurance eligibility or financial status. I understand that eligibility under a patient assistance program is subject to the pharmaceutical companies' approval and my continuing compliance with all eligibility requirements.

I have read, understand and agree to all of the above. This consent is valid until rescinded in writing. A photocopy or faxed copy may be used in place of the original.

_____
Signature

_____
Print Name

Date of Signature: _____-_____-_____

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MAP Program Guidelines—page 1 of 2

Carilion Clinic employs a Medication Assistance Program team to organize applications for patients needing medications, and who qualify for indigent programs offered by pharmaceutical companies. By signing these guidelines, you are agreeing to abide by the following terms:

1. I certify that the information provided by me represents correct and accurate data to the best of my knowledge and that the information is given freely so that I can be considered for the Medication Assistance Program (MAP). I understand that false information given by me to the MAP could subject me to civil as well as criminal penalties.
2. I understand that this is not a reimbursement program. I am solely responsible for any medications I have previously purchased and may need to purchase in the future.
3. I understand that there may be delays in getting my medications and if I should run out of medication before I receive it through MAP, I am solely responsible for obtaining my medications until they arrive. Additionally, should there be any medications that are unavailable through the program, I understand it is my responsibility to obtain those medications without reimbursement from the program. The MAP offices cannot guarantee the provision of medications obtained through the medication assistance programs sponsored by various drug manufacturers. I understand that I have the option of purchasing the medications at the retail pharmacy of my choice.
4. I must notify the MAP staff in the event that my medical provider discontinues any of my medications, changes a dose or the number of times that I take my medication each day. Failure to provide notification of medication changes may result in an interruption of my medication.
5. It will be my responsibility to replace medications that are lost or stolen after I have obtained them from the program.
6. I understand that I should be notified when my medication is delivered to the physician's office. It is my responsibility to pick up my medications once I am notified. Failure to pick up my medications within one month of delivery could result in my medications no longer being available.
7. It is my responsibility to notify the MAP staff in a timely manner when I need more medication to be ordered through the program. I must notify MAP when medication is received whether at a retail pharmacy, physician office or home address. Failure to give enough notice may result in me having to pay for my medication at the retail pharmacy of my choice.

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MAP Program Guidelines—page 2 of 2

8. I agree to follow my medical provider's instructions regarding my care, including maintaining routine medical appointments, appropriate labs, EKG, x-rays and any other instructions necessary for my care.
9. I must notify the MAP staff immediately in the event of any changes regarding my household such as a change of address, telephone number, household status (i.e. marriage, divorce), number of people in household, change of income, new insurance, etc.
10. I must complete the annual re-enrollment process. I must also provide income documentation upon request.
11. There are occasions when an application the MAP submits to a drug manufacturer is rejected for any number of reasons. The rejection may be mailed to my home address. It is my responsibility to notify the MAP of any rejections so the program may appeal and resubmit the application on my behalf.

I have read and understand pages one and two of the MAP Program Guidelines and agree to follow all of the guidelines for the duration of any assistance I receive from the MAP. I understand that any violation of any part of the policy may make me ineligible for services provided by the MAP.

Patient Signature _____

Date of Birth _____-_____-_____

Date of Signature: _____-_____-_____

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Zero Income Statement (To be completed only if you do not have any income)
If you did not file a Federal Income Tax Return, you must also complete Form 4506-T ***Request For Transcript of Tax Return***. (url for form on IRS website: https://www.irs.gov/pub/irs-pdf/f4506t.pdf)

Date _____-_____-_____

Patient Name _____

Date of Birth _____-_____-_____

I attest to having zero income at this time. The reason I have zero income at the present time is:

- ☐ Unemployed short-term
- ☐ Unemployed long-term
- ☐ Declared disabled by my physician
- ☐ Temporarily unable to work due to illness/health
- ☐ Unemployed due to illness or disability

Circle the status areas below if you have applied for financial assistance from any of the following:

Social Security Disability……..…….…… Pending – Accepted – Denied

Medicaid……..…… Pending – Accepted – Denied

Medicare Part-D Low Income Subsidy……..... Pending – Accepted – Denied

Financial Assistance (Charity Care) with Carilion Clinic... Pending – Accepted – Denied

In the space below, explain your living arrangements and current financial situation.
For example, live with family, friends, or homeless, etc. Also explain how you obtain groceries, pay for utilities, rent, etc.

_____

_____

_____

_____

_____

_____

I agree to notify the Medication Assistance Program if and when my current financial status changes.

Patient Signature: _____