MEDICATION ASSISTANCE PROGRAM (MAP)

Application Packet

This packet of information and forms will help you apply for local medication assistance program. It is important that you fill this paperwork out completely and have the proper documents to turn in for consideration. Failure to do so will delay the enrollment process. 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 State 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 Card and Medicare Part D (prescription coverage) 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 (dated 1-1 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.

CMAP (Roanoke) 540-981-7647

NRVMAP (Radford) 540-731-2414

GMAP (Giles) 540-922-4282

INFUSION MEDICATION/CMAP 540-981-7506

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 or deliver it in person (best to call ahead for office hours).

GILES MAP
159 Hartley Way
Pearisburg, VA 24134
Phone : 540-922-4282
Fax: 540-921-1824

ROANOKE MAP
1906 Belleview Ave
Ground Floor
Roanoke, VA 24014
Phone: 540-981-7647
Fax: 540-344-0301

NRV MAP
P.O. Box 5
Radford, VA 24141
Phone: 540-731-2414
Fax: 540-731-2413

INFUSION MEDICATION
1906 Belleview Ave
Ground Floor
Roanoke, VA 24014
Phone: 540-981-7506
Fax: 540-343-1003

Date _____ Email Address _____

Name _____
(First) (Middle) (Last)

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

Home phone number _____ Cell Phone _____

(CIRCLE ONE)
Mailing address:

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

Street Address/P.O. Box _____

City _____County _____State _____ Zip _____

Physical address (if different from above):

Street Address _____

City _____County _____State _____ Zip _____

Circle your answer:

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

Referred by: _____

-

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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_____

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 age 18) receive Social Security or Social Security Disability 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).

***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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Insurance

Mark in the appropriate column below to indicate if you have any of the following types of coverage and provide front/back copy of any card with yes answer:

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

If you have Medicare, please answer the following questions:

1. 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
2. If you have Medicare Part D please provide a copy of your out of pocket statement.

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 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. The purpose is to expedite the ordering process by eliminating having to mail forms to the patient for signatures.

Patient Signature: _____

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Carilion Medication Assistance Program
Participation & Consent to Release Information

I authorize Carilion Clinic and any Carilion Medication Assistance Advocate ("Carilion") to help me obtain free or reduced rate prescribed medications for use in my treatment from independent or manufacturer patient assistance programs ("Patient Assistance Program"). I authorize Carilion to complete necessary form(s), using information supplied by me, and to sign my name on all form(s) required for participation in a Patient Assistance Program(s) for pharmaceuticals that I have been prescribed.

I authorize Carilion, Patient Assistance Programs, and any insurer or healthcare provider to disclose to any Patient Assistance Program financial and insurance records and information, personal identifying information, and necessary medical records and information, as necessary for my enrollment or participation in a Patient Assistance Program. ***I acknowledge that the released information may contain alcohol, drug abuse, psychiatric treatment, sexually transmitted disease treatment, HIV testing, HIV results or AIDS information and I hereby authorize and consent to this disclosure.*** _____ **(Initial)** There is a potential that information disclosed may be redisclosed by the recipient and no longer protected by law.

I grant the Patient Assistance Program(s), pharmaceutical companies and manufacturers 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 shall terminate on the earlier of: i) my no longer being eligible to participate in the Carilion Medication Assistance Program; (ii) my electing to no longer participate in the Carilion Medication Assistance Program and notifying Carilion; or (iii) my rescinding this consent in writing and notifying Carilion. 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 or misleading information or declaration(s) by me to the MAP will make me ineligible for MAP. I further understand that a false or misleading declaration by me may result in pharmacy assistance adjustments for which I would not otherwise have qualified and may subject me to civil and 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 when 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 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, adds additional 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 (1) 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.

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.

HIPAAPrivacy / Confidentiality Permission Form

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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.

_____
Signature Date

_____
Print Name

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