Mountain Empire Older Citizens, Inc.

PO Box 888
Big Stone Gap, VA 24219
www.meoc.org

(P) (276) 523-4202
(F) (276) 523-4208
info@meoc.org

Dear Applicant,

Pharmacy Connect of Southwest Virginia is designed to assist individuals of all ages who need help purchasing medications.

When you complete the following application, it is vital that you have the correct medication, strength and dosage listed. The prescribing doctor must also be listed with the medication.

Because this program is set up to be a link between the pharmaceutical companies, the physicians and the patients, EMERGENCY ASSISTANCE CANNOT BE PROVIDED. Each application for the individual medication may take as long as 4 to 6 weeks for delivery.

The pharmaceutical companies that provide free medicines require proof of income. No application can be completed without this information. The following documents are acceptable as proof of income:

1. W-2 withholding forms
2. Pay stub for last month's wages
3. Income tax returns
4. Documentation of workman's compensation
5. Written and signed verification of wages from your employer
6. Court verification of child support or alimony
7. Latest leave and earnings statement for military personnel
8. Social Security, SSI, Black Lung or Survivor's Benefits (copy of check award letter or copy of bank statement if your check is direct deposit)
9. Letter of support from a friend or relative supplying you with food or shelter
10. Copy of ADC/Supplemental Nutrition Assistance Program (SNAP) Award Letter if this is your only means of support

Please mail your proof of income and completed application to MEOC, PO Box 888, Big Stone Gap, VA 24219. If you have questions or need assistance filling out the application, please contact Amber Dingus at (276) 523-4202.

Attention Medicare Beneficiaries

Who Have Medicare Part D Prescription Coverage and
Who Are in the "*Donut Hole*"

If you do not have Medicare, ignore this form.

You may be eligible for assistance through the Pharmacy Connect Program.

In order to determine if you qualify, the following must accompany this application:

1. **Proof of Household Income**: Examples are Social Security award letter, SSI, Black Lung,
   SSA-1099 or Pension Statement

2. **Copy of Insurance Cards**—Both Medicare Card and Medicare Part D Card (front and back of each card)

3. **Copy of Low Income Subsidy (LIS) Determination Letter**—If you have not applied for LIS, call the Social Security Office to apply.

4. **The EOB Statement and/or Summary of Monthly or Annual Drug Expenses**—(A printout from your pharmacy)

5. **A Complete List of Medicines You Are Currently Taking**

Be sure to complete the following application and sign and date the last page.

The last page is a consent form that gives us permission to share your information with the pharmaceutical companies in order to determine your eligibility for free medicine.

Pharmacy Connect of Southwest Virginia
1-276-523-4202 or 1-800-252-6362

This application must be completed in full by the patient, guardian, social/case worker or a family member. Remember—**proof of income must be included with this application.** All information is necessary to help you apply for medications in a timely manner; incomplete applications cannot be processed.

Patient's Name: ____

Address: ____

City: ____________________ State: _________ Zip: ______________ County: ______________

Telephone: ____________________________ Cell Phone: _______________________________

Contact Person: ____________________________ Contact Phone: _________________________

Social Security Number:	Birthdate: (m/d/y)
Race: Sex:	Marital Status:
U.S. Resident: Yes_________ No __________ U.S. Veteran: Yes_________ No __________	Number in Household: ____________ Ages of Persons in Household ________________
Health Insurance	**Source of Income**
Please answer (a) through (e) as: YES, NO, or NOT ELIGIBLE	Salary/Wages:
(A) Medicaid	Social Security/SSI/Disability:
(B) Medicare:	Pension/VA:
(C) Veterans/Champus:	Worker's Comp./Unemployment:
(D) Commercial (Such as Blue Cross)	Food Stamps/AFDC/TANF:
(E) Employer:	Other (Specify):

Physician's Name: ______________________________ Phone Number: ____________________

Allergies: Please indicate any drug allergies by checking the boxes below.

None: ________	Penicillin: ______	Codeine: _______	Sulfa: _________	Aspirin: ________

PLEASE LIST EACH MEDICATION YOU ARE TAKING SEPARATELY

Medication Name and Strength	**How many times a day do you take this medication?**	**For what illness is this medication prescribed?**	**Name of doctor (if different from above)**
Example: ***Glucotrol XL 5mg***	***One tablet a day***	***Diabetes***	***Dr. John Doe***
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3.			
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