



Charitable Foundation
MEDICINE ASSISTANCE PROGRAM
 PO BOX 1089
 JONESBORO, AR 72403
 (870) 934-5400

INFORMATION SHEET
MUST COMPLETE ENTIRELY

TODAY'S DATE _____

CONTACT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST _____

PHONE NUMBER HOME _____ WORK _____ CELL _____ MESSAGE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PERSONAL INFORMATION

DATE OF BIRTH _____ SOC. SECURITY NUMBER _____ MALE _____ FEMALE _____

US CITIZEN **Y N** US RESIDENT **Y N** US VETERAN **Y N** LEGALLY DISABLED **Y N**

MARITAL STATUS **MARRIED DIVORCED SINGLE WIDOWED**

NUMBER IN HOUSEHOLD (INCLUDING THE PATIENT) _____ RACE(OPTIONAL) _____

FINANCIAL INFORMATION (PLEASE INCLUDE ALL HOUSEHOLD INCOME)

<u>MONTHLY INCOME</u>	<u>PATIENT</u>	<u>SPOUSE/OTHER</u>
WAGES:	_____	_____
INTEREST:	_____	_____
ALIMONY:	_____	_____
UNEMPLOYMENT:	_____	_____
DISABILITY:	_____	_____
SOCIAL SECURITY:	_____	_____
SSI:	_____	_____
PENSION:	_____	_____
OTHER:	_____	_____
TOTAL MONTHLY:	_____	_____

DID YOU FILE A TAX RETURN FOR 2009? **Y N**

