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)

MONTHLY INCOME	**PATIENT**	**SPOUSE/OTHER**
WAGES:	_________________________	_______________________
INTEREST:	_________________________	_______________________
ALIMONY:	_________________________	_______________________
UNEMPLOYMENT:	_________________________	_______________________
DISABILITY:	_________________________	_______________________
SOCIAL SECURITY:	_________________________	_______________________
SSI:	_________________________	_______________________
PENSION:	_________________________	_______________________
OTHER:	_________________________	_______________________
TOTAL MONTHLY:	_________________________	_______________________

DID YOU FILE A TAX RETURN FOR 2006? **Y N**

INSURANCE INFORMATION

DO YOU HAVE ANY PRESCRIPTION COVERAGE? **Y** **N**

MONTHLY OUT OF POCKET MEDICAL EXPENSES: ________________________
(Prescription or over-the-counter medication costs, hospital or physician bills, etc. anything actually paid out of the patient's pocket.)

DO YOU HAVE MEDICARE? **Y** **N** MEDICARE ID#____

ARE YOU ENROLLED IN A MEDICARE PART D DRUG PLAN? **Y** **N**

IF YOU HAVE MEDICARE, HAVE YOU APPLIED FOR THE LOW INCOME SUBSIDY (LIS) FROM SOCIAL SECURITY? **Y** **N**

DO YOU HAVE MEDICAID? **Y** **N**

HEALTHCARE INFORMATION

MEDICAL CONDITIONS ____
____

DRUG ALLERGIES____ _____

DOCTOR'S NAME (first and last) PHONE NUMBER ADDRESS

____
____

MEDICATIONS STRENGTH/MG # OF TIMES DAILY DR

____
____
____
____
____
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____
____
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____
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PATIENT SIGNATURE____DATE_____________________________

BY SIGNING THIS APPLICATION YOU AGREE THAT ALL OF THE INFORMATION YOU HAVE PROVIDED IS CORRECT. YOU ALSO AGREE THAT YOU ARE RESPONSIBLE FOR REPORTING ANY CHANGES IN YOUR FINANCIAL SITUATION OR INSURANCE COVERAGE.