SOUTHSIDE VIRGINIA
MEDAssist

403 Spring Street, Danville, VA 24541 ◆ 320 Hospital Drive, Martinsville, VA 24112
Voice: 434-791-3630 ext. 311; Fax: 434-791-4088 ◆ Voice: 276-634-4994

PATIENT APPLICATION

PLEASE TYPE OR PRINT CLEARLY.
INCOMPLETE FORMS WILL BE RUTURNED FOR COMPLETION.

❒New Patient Application ❒Re-Application

Social Security#: ____ - ____ - _____ Date Of Birth: ____/____/19_____

Name (First): _____ Middle Initial: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____-_____ Secondary Phone: (_____) _____-_____

The following questions are optional. Please check the appropriate answer that best describes the patient:

Gender (OPTIONAL): ❒Male ❒Female

Marital Status: ❒Divorced ❒Married ❒Separated ❒Single ❒Widowed

Ethnic Group: ❒African-American ❒Asian ❒Caucasian
❒Hispanic ❒Native American ❒Other

Please check the answer that best describes the patient on the date of this application:

❒Disabled ❒Employed Full-Time ❒Employed Part-Time ❒Retired
❒Self-Employed ❒Student Worker ❒Temporary/Seasonal ❒Unemployed

Total Number of People in Household: _____

Household Income Information:

Source: (Please describe the source of all the income supporting your household)	**Amount:** (Monthly)

Insurance Information:

Insurance Type	Patient Covered		Prescription Benefit Available Under Coverage	
	Yes	No	Yes	No
Employer/Group Insurance	❒	❒	❒	❒
Medicaid	❒	❒	❒	❒
Medicaid QMB	❒	❒	❒	❒
Medicare	❒	❒	❒	❒
Military	❒	❒	❒	❒
Self-Insured	❒	❒	❒	❒
Supplemental	❒	❒	❒	❒
Veterans	❒	❒	❒	❒
Other: _____	❒	❒	❒	❒
Uninsured:	❒	❒	❒	❒

Please list each of the physicians/providers currently treating the patient:

Name	Date Last Seen

Please describe the patient's current medical condition:

_____
_____
_____
_____
_____
_____

Please list all prescription medications currently being taken by the patient:

Medication Name	Strength	How many per day?	Prescribing Physician

Please read the following:

I verify that the information supplied on this form is true and accurate according to the best of my knowledge. I agree to contact the MEDAssist program if any of the information requested on this form changes, including but not limited address and household income information. I understand that MEDAssist will attempt to help me access free medication typically in 3 month supplies and I understand that it will be my responsibility to contact MEDAssist immediately should any of my medications change. I understand that should I be found guilty of extending false information, that MEDAssist will revoke any benefits and I will no longer be eligible for their services.

I give my MEDAssist Case Worker the authority to contact my physician(s)/provider(s) and exchange any information necessary in order to apply for free medications through The Pharmacy Connection. I also give my MEDAssist Case Worker the authority to exchange information with the pharmaceutical companies that manufacture my medications in an effort to access free medication.

I authorize my MEDAssist Caseworker to sign any necessary forms on my behalf when ordering medications for me through The Pharmacy Connection. I understand that this will speed up the ordering process by making it unnecessary for the forms to be sent to me and then back to MEDAssist. This signature authorization is valid as long as I am receiving services through MEDAssist.

I understand that should I be found eligible to receive services through MEDAssist, that I will be expected to re-apply for services on an annual basis.

Patient Signature: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

In order to process your application, please provide a copy of each of the following:

- **Valid State Issued Picture ID (example: Drivers License)**
- **Copy of the patient's COMPLETE most recent tax return (W2's alone are not acceptable). If you do not file taxes, please complete the attached form number 4506.**
- **Verification of entire household income for the last 30 days**

Once the application is completed you can mail or hand-deliver it to:

MEDAssist
403 Spring Street
Danville, VA 24541

OR

Memorial Hospital
Attn: MEDAssist
320 Hospital Drive
Martinsville, VA 24112

OFFICE USE ONLY:

Date Application Received: _____/_____/_____ Received by: _____

Eligible: Yes No

If no, why not: _____

_____

_____

Notes/Comments: _____

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