Medication Assistance Program (MAP) Checklist

Before sending your application, please make sure you have completed the following:

- Complete the application entirely. The application and any information included with your application will be returned to you if the information provided is incomplete. This may cause a delay in processing your application.

- Attach copies of proof of income for you and all dependent persons in the household. Acceptable documents:
    - Federal Income Tax (form 1099 or 1040EZ) with appropriate schedules (C and/or F) **OR** Social Security benefit statement, award letter, or bank statement (showing direct deposit)
    - Current pay stub for all employers (within the last 2 months)

- Attach a list of current medications with strengths and dosing instructions.

- List Doctor with address and phone number.

- Copy of prescription coverage (card), if applicable.

- Sign and date the application.

Medication Assistance Program (MAP) Application

Full Name:_____ Gender: Male □ Female □

Mailing Address:_____
City/State/Zip:_____
County:_____

Phone:_____ Work:_____

Social Security #:_____ Allergies:_____

Marital Status:_____ Date of Birth:_____

Health Conditions:_____

Ethnic Group:
□ African-American □ Caucasian
□ Hispanic □ Native American
□ Asian □ Other_____

Citizenship: □ US □ Other_____

Prescription Coverage: □ Yes □ No
If Yes, name the provider:_____

Number of People in Home:_____
Total Monthly Income_____

Employment Status:_____

Source of Income:
Child Support_____
Pension_____
Salary/Wages_____
SS_____
SSA/Retirement_____
Other_____

It is the patients' responsibility to notify the medical center staff six weeks before the last does of medication is taken so the reorder process can take place in a timely manner.

The MAP program was developed to assist qualified patients to secure prescription medication. Federal poverty guidelines are used to determine eligibility.

I give the MAP Patient Advocate permission to sign my name to all applications regarding the medication assistance program.

Signature:_____ **Date:**_____

Medication Assistance Program (MAP) Participation Agreement

I certify that I have read and understand services offered by the Medical Assistance Program (MAP) and my responsibilities as a Medication Assistance Program participant. I also certify that the information I have provided to the Medication Assistance Program is accurate and true to the best of my knowledge and belief. I understand that participation with the Medication Assistance Program by physicians, pharmacists, pharmaceutical companies, and other health care professions is strictly voluntary and that they receive no pay for their services. I also understand that application to MAP does not guarantee receipt of medication or other services. By signing this agreement, I release MAP, its service providers, affiliated drug companies, and any public or private agencies or financial supporters and their agents and assigns from any and all claim of liability in performing services or related to the services I receive from the Medication Assistance Program. I give the MAP Patient Advocate permission to sign my name to all applications regarding the Medication Assistance Program.

Release of Information Agreement

I authorize a representative of MAP to inspect my health records whenever necessary to confirm prescribed medications and associated dosages in order to obtain low cost medications from pharmaceutical companies. I also authorize the Medication Assistance Program to discuss my medical needs with my physician when necessary to ensure that medications are being appropriately prescribed and used. Additionally, I give MAP permission to verify my income through the Department of Social Services, Social Security Administration, and Veterans Administration, my employer, or any other company, business or organizations from which I receive income. This authorization is good as long as MAP is assisting me or until I revoke it in writing. A revocation may be sent by certified mail to MAP, 4038 Thomas Nelson Highway, Arrington, VA 22922, and will become effective on the date of receipt by MAP.

Signature of Patient:_____ Date:_____

Print Name of Patient_____ Date:_____

Patient Instructions
Medication Assistance Program (MAP)

Yours to Keep

1. When we complete your application, we will send it to your doctor for signature and prescriptions.

2. Once the applications have been mailed, ***it could take 4-6 weeks*** for the medicine to be sent by the drug companies, sometimes longer.

3. The medicine is usually sent to your doctor's office and you will be notified to pick it up.

4. **It is very important that you call us when you have 45 days (6 weeks) left of your medicine.** We need to order refills before you run out of medicine. You will usually receive a 90 day supply. Please use your calendar to remind yourself when to call us. When you need a refill please call us at 434-263-4000 and select Option 2.
   *****Be prepared to buy your medication if it does not come in before you need it.*****

5. If your medications change, for any reason, please contact us immediately. Your doctor may increase, decrease, or stop medication or add new medication. ***YOU MUST*** tell us if any changes occur.

6. There is no guarantee that the drug companies will send your medicine. They will determine if you are eligible. Sometimes they discontinue medicines.

7. We will do our best to help you, but please ***DO NOT*** count on this program as your ***only*** source of medication. Be prepared to pay for your medicines or get samples if necessary.

8. The drug companies will send you paperwork. Please bring it to us. There may be Rx numbers or refill applications that will make it easier for us to reorder.

9. Please call us at 434-263-4000 and select Option 2 if you have any questions.

Blue Ridge Medical Center
4038 Thomas Nelson Highway
Arrington, VA 22922

Main Phone: 434-263-4000
Fax: 434-263-4160
Email: Joy@brmedical.com