Chenango Health Network (CHN)
Prescription Assistance Program Application

This information is required by the pharmaceutical companies to process your request for assistance.

Name _____ Date of Birth _____

Address _____

Social Security # _____ Marital Status _____

Phone # _____ ☐ I give my permission for CHN to leave a message on my voicemail about my prescriptions. (optional)

☐ I give my permission for CHN to speak with the following family member/friend about my prescriptions:

(optional) Name _____ Phone # _____

Do you have Medicare? _____ If yes, ID #: _____ **(Please include copy of card.)**

Do you have Medicare Part D or any other Medicare prescription coverage? _____ **If yes, you MUST include a copy of front and back of insurance card.**

Do you have private prescription coverage or <u>any</u> other type of RX coverage? _____ **If yes, you MUST include a copy of front and back of insurance card.**

(PLEASE NOTE: Medicaid recipients are not eligible for this program.)

Are you disabled (per Social Security)? _____ Are you a veteran? _____

Chenango Health Network does not release personal information to anyone except to gain assistance in providing you with the help you seek. Please sign this form, indicating that Chenango Health Network has your permission to share or obtain personal, confidential information to those organizations or individuals who may assist in providing that help or who may require accounting or monitoring information.

_____ Date: _____
Signature

I authorize Chenango Health Network, when acting as my Patient Advocate, to sign applications for prescription assistance for me.

_____ Date: _____
Signature

LIST ALL MEDICATIONS YOU TAKE (attach extra sheet, if needed):

Medication

List any allergies to medications:

List all medical conditions:

Physician's Name, Address and Phone #: _____

Referred to CHN by: _____

List gross monthly amounts of income for all household members. (**Please include** proof of last 30 days' income. If income is Social Security, please include a copy of the latest year's benefit amount letter.)

Source of Income	**Self**	**Other**
	$	**$**
	$	**$**
	$	**$**
	$	**$**
Total Monthly Income	**$**	

Total People in Household

_____

If you need assistance with this application, please contact our office at 607-337-4128. Please return your completed application with proof of income documentation to:

Chenango Health Network, 24 Conkey Avenue, Norwich, NY 13815

Fax: 607-337-4276

I have provided Chenango Health Network with complete and accurate information.

_____ Date: _____

Signature