Application for Services

Please fill out this form to completion and bring it with you to the pharmacy.

Name: _____

Address: _____

_____

Phone Number: _____

Social Security # _____ ☐ Female ☐ Male

☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Caucasian ☐ African-American ☐ Hispanic ☐ Other

INSURANCE:

Medicaid #: *(if rejected, we need a copy of Medicaid letter)*

Medicare # **VA**

Other Insurance ***(Name and Policy No.):***

Notes:

Primary Care Doctor:

Other Doctors:

FINANCES (Fill in all monthly income and assets; indicate pay period—week, month)

Salary/Wages from:		
Social Security:		
SSI (Supplemental Security Income):		
Pension/Retirement from:		
Unemployment Compensation:		
Workers Compensation:		
Alimony/Child Support:		
TOTAL GROSS INCOME FOR HOUSEHOLD: $		

ASSETS

Checking Acct:		
Savings Acct:		
CD's:		
IRA/retirement/annuity:		
Other:		
TOTAL:		

MEDICATIONS: *List all medications (prescription, over-the-counter, herbals, vitamins, etc. that you take)*

Name of Medicine	Strength	How Taken	Prescribing Doctor

ALLERGIES: *List each allergy and reaction you have below.*

Medicine: **Allergy:**

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Medicine: **Allergy:**

I certify that I have NO health insurance, including Medicaid, Medicare, and VA. I also state that the information I have provided is true and complete to the best of my knowledge. I have read the information above and agree with it. I hereby give CCCP permission to verify this information.

Name (written out): **Date:**

Signature:

Number in household: **200% of poverty:**

Eligible: **Not Eligible:**

Reason:

Signed: **Date:**

Monthly income & source: **Date:**