Medication Assistance Program

Patient Information **Date:** _____

Patient Name: _____

Contact/Caregiver Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (_____) _____ Patient's Date of Birth: _____

Financial Information

1. Monthly income: $_____ Single: _____ Married: _____
   Number of dependent children: _____
   Verified: _____

2. Monthly cost of PD meds: $_____ Cost of other meds: $_____
   Monthly/annual cost for health care: $_____
   Monthly cost for health care for other immediate family members: $_____

3. Do you have health insurance: Yes:_____ No:_____
   Name of insurance company: _____
   Do you have prescription coverage? Yes_____ No_____
   Family member health insurance coverage? Yes__ No___
   Rx: Yes_____ No_____

4. Special Financial Concerns: _____

5. Pharmacy Name: _____ Phone:(_____) _____
6. Physician Name: _____ Phone:(_____) _____

Name and Dose of Medication _____

Refills/prescription # of bottle: _____ Allergies: _____

Ever order through Advanced Care Pharmacy Services? Yes_____ No_____

Please Note: Our Medication Assistance Program is serviced through Genoa Pharmacy. Medication will be filled by Genoa Pharmacy and sent through Mail Order. To contact the Pharmacy directly please call (586) 323-8270.

Complete the application and return to Stephanie Woznak via email at respite@parkinsonsmi.org
or fax to 248-433-1150 or mail to
30400 Telegraph Rd. Suite 150. Bingham Farms, MI. 48025