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