

**OZANAM CHARITABLE PHARMACY
ACCESS YOUR RX PROGRAM
PATIENT INTAKE FORM**

571 Dauphin Street
Mobile, AL 36602
Tel: 251-445-0981 Fax: 251-445-0982

Social Security #: _____	Medicare #: _____	County: _____
Last Name: _____	First Name: _____	MI: _____
Mailing Address: _____	Race/Ethnicity: ___ White ___ African Amer ___ Other	
Street Address: _____	Birthdate: ___/___/___	Gender: ___ Male ___ Female
City/Zip: _____	Home Phone: () _____	

Did you file income taxes last year? Yes No	Are you a legal resident of the U.S.? Yes No
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Employment Status: ___ Retired ___ Disabled Are you a veteran or veteran's spouse/widow? Yes No
___ Full time ___ Part time Number living in household (including client): _____

Marital Status: ___ Married ___ Not Married ___ Widowed Spouse's Birthdate: ___/___/___

Spouse's Name: _____ Spouse's Social Security # _____

Primary Physician: _____
Name Address Phone

Emergency Contact: _____
(not living with you) Name Phone Relationship

SOURCES OF INCOME

(We MUST HAVE a copy of proof of income for EVERYONE who lives in your household)

TOTAL MONTHLY INCOME \$ _____ LAST CALENDAR YEAR INCOME \$ _____

Salary/Wages \$ _____ Unemployment \$ _____ Social Security Disability \$ _____

Veteran's Benefits \$ _____ Child Support \$ _____ Social Security \$ _____

Workmen's Comp \$ _____ Pension \$ _____

Railroad Retirement \$ _____ Interest Income \$ _____ Other \$ _____

(Attach copies of W2 forms, tax returns, social security benefit statements, or other sources of income.)

TOTAL MEDICAL EXPENSES _____ For Example: over-the-counter medicines, health insurance premiums, co-pays, medical supplies, Dr. and hospital visits, lab fees (a monthly average)
TOTAL AMOUNT OF EXPENSES _____ PRESCRIPTION DRUG COSTS _____ For example: mortgage or rent, utilities, _____ (a monthly average) Insurance (not health insurance) (monthly average)
(The information collected will be kept STRICTLY CONFIDENTIAL)

MEDICAL INFORMATION

Are you currently enrolled in another prescription assistance program or discount program? Yes No

Are you enrolled in Medicare VA Benefits SLMB QMB Q1-1

Do you have any health insurance coverage? _____
 (other than Medicare) Company Policy #

Do you have a Medicare Supplemental Policy? _____
Company Policy #

If you have more than one prescribing physician, please attach a list with each doctor's name, address and telephone number. The Ozanam Charitable Pharmacy cannot guarantee that you will receive the medicines requested.

Medication	Directions/ Strength	Name, phone number and address of prescribing doctor	Cost per month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical Conditions (please circle) Heart Asthma High BP Ulcer Glaucoma

Other: _____

Medication Allergies (please circle) None Sulfa Penicillin Aspirin Codeine Iodine

Other: _____

I hereby state that the information I have given is correct to the best of my knowledge and the Ozanam Access Your Rx Program has my permission to obtain and release information deemed necessary to obtain my medication. I understand that the Ozanam Access Your Rx Program cannot guarantee assistance. I understand that omitting or falsifying information are grounds for denial of services.

Patient Signature: _____ Date: _____

Ozanam Program Coord. Signature: _____ Date: _____