PATHS
Live Life. Be Healthy.
MEDAssist Program

133 South Ridge St. ◊ Danville, Virginia 24541
Voice: 434-791-4794 Option 3 ◊ Fax: 434-791-4048

Please include the following to PATHS MEDAssist along with patient application:

Current Federal Tax Return Form 1040

- 1040 (first & second page)
- Self-employed must submit the Schedule C portion of their tax return.
- 1099 and W-2 **"cannot be accepted"**

Proof of Income

- Salary Wages should be a copy of **"Last 30 days"**
- Social Security should be a copy of **"Current Year Benefit Letter"**
- Bank statements **"cannot be accepted"**

No Income

- Current (SNAP) Food Stamp Verification / Current Non Filing Form
- Letter of Support

Copy of Picture ID

***MEDAssist would like to apologize for any inconvenience this may cause. However, due to requirements made by the pharmaceutical companies the documents are needed to process your application.**

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MEDAssist Patient Application

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INCOMPLETE FORMS WILL BE RETURNED FOR COMPLETION.
Reason for returned application:
Missing income documentation, tax forms, and current medication list.

Social Security#: ____ - ____ - _____ **Date of Birth:** ____/____/_____

Name (First): _____ **MI:** ___ **Last:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone: (_____) _____-_____ **Secondary Phone:** (_____) _____-_____

Gender: ☐Male ☐Female ☐ Transgender – Male to Female ☐ Transgender – Female to Male ☐ Genderqueer, neither exclusively male or female ☐ Choose not to disclose

Marital Status: ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed

Ethnic Group: ☐African-American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other ☐ Decline to Specify

Please check the answer that best describes the patient on the date of this application:
☐Disabled ☐Employed Full-Time ☐Employed Part-Time ☐Retired
☐Self-Employed ☐Student Worker ☐Temporary/Seasonal ☐Unemployed

Total Number of People in Household: _____

Household Income Information:

Income of entire Household: (Please make PATHS MEDAssist aware of all income in household)	**Amount:** (Monthly)

	Yes	No
Filed Federal Taxes	☐	☐

Insurance Information:

Insurance Type	**Patient Covered**		**Prescription Benefit Available Under Coverage**	
	Yes	**No**	**Yes**	**No**
Uninsured	☐	☐	☐	☐
Health Insurance	☐	☐	☐	☐

If yes what kind:

Please list all medications currently taken:

Medication Name	Strength	How many per day?	Physician Name

Please read the following:

- I verify that the information supplied on this form is true and accurate according to the best of my knowledge. I agree to contact the PATHS MEDAssist program if any of the information requested on this form changes, including but not limited to, address and household income information. I understand that MEDAssist will attempt to help me access free medication typically in 3 month supplies and I understand that it will be my responsibility to contact PATHS MEDAssist immediately should any of my medications change. **I understand if am found guilty of extending false information, that PATHS MEDAssist I will no longer be eligible for their services.**
- I give my PATHS MEDAssist Case Worker the authority to contact my physician(s) and exchange any information necessary in order to apply for free medications through The Pharmacy Connection. I also give my PATHS MEDAssist Case Worker the authority to exchange information with the pharmaceutical companies that manufacture my medications in an effort to access free medication.
- I authorize my PATHS MEDAssist Caseworker to sign any necessary forms on my behalf when ordering medications for me through The Pharmacy Connection. I understand that this will speed up the ordering process. This signature authorization is valid as long as I am receiving services through MEDAssist.
- I am expected to update or reapply for the program for on an annual basis.
- **I understand that if I am approved to receive assistance through PATHS MEDAssist that I will pick-up all of my medications when I am notified and if there is a reason that I cannot pick-up the medications I will contact PATHS MEDAssist.**
- **I also understand that if I have 2 returns of medication I will be DISENROLLED FROM PATHS MEDASSIST AND WILL NOT BE ALLOWED TO BE RE-ENROLLED UNTIL THE NEXT YEAR.**

Patient Signature: _____ **Date:**_____/_____/_____

Witness: _____ **Date:**_____/_____/_____

In order to process your application, please provide a copy of each of the following:

1. Valid State Issued Picture ID **(example: Drivers License)**
2. Copy of the patient's COMPLETE most recent tax return. **1040 and Schedule C tax forms only. (W-2 forms are not allowed).**
3. Verification of **entire household income** for the **last 30 days.**

Once the application is completed, you can mail or hand deliver it to:

PATHS MEDAssist
133 South Ridge St.
Danville, VA 24541

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Patient Name (Printed) _____ **Date:** ___/___/____

Disclosures to Family & Friends: I authorize disclosures of my health/dental information, relevant to current treatment to:

Name & Relationship: _____ In Person or By Phone

Name & Relationship: _____ In Person or By Phone

Name & Relationship: _____ In Person or By Phone

I authorize PATHS MEDAssist to leave messages related to my care of my answering machine/voicemail ☐Yes ☐ No

This page must be signed.

Signature: _____ **Date:** ____/____/_____

This document contains information pertaining to policies and procedures that apply to how PATHS MEDAssist operates in terms of providing your health care. If you have questions in regards to anything, you have read. Please reach out to PATHS MEDAssist at the following

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