Medication Assistance Programs Application

APPLICANT INFORMATION – PLEASE PRINT

Name: _____ _____ _____
Last First Client I.D. Male or Female

Mailing Address: _____ _____ _____
(Must be a street address) Telephone Date of Birth

_____ _____ _____ _____
City County State Zip

I am presently living in Florida. _____ Yes _____ No

I have diabetes and require insulin. (prescription attached.) _____ Yes _____ No

I have epilepsy and require medication. (prescription attached.) _____ Yes _____ No

I do not have Medicaid or health insurance that covers prescription medication, or I have an insurance co-pay or deductible I cannot afford. _____ Yes _____ No

My annual net family income is $_____

There are _____people in my family.

My assets, other than my homestead, are below $2,500. _____ Yes _____ No

MEDICAL INFORMATION

Do you have any known allergies/drug reactions? _____ Yes _____No
If yes, please name the drug(s):

_____
_____
_____

Do you use any medical devices to administer or monitor your medical condition? _____ Yes _____No

If yes, please name the medical device(s):

_____
_____
_____

List prescription medications you are now taking which were not received from Central Pharmacy:

_____
_____
_____

List Over-the-Counter medications you are now taking:

_____
_____
_____

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Please check if you have any of the health conditions listed below:

_____Arthritis
_____Ulcers
_____Diabetes
_____Cancer
_____Epilepsy
_____Asthma
_____Heart Conditions
_____Kidney Disease
_____Lung Disease
_____Rheumatic Fever
_____Tuberculosis
_____Liver Disease
_____Blood Clotting Disorders
_____High Blood Pressure
_____Parkinson's Disease
_____Anemia
_____Pregnancy
_____Other _____

I acknowledge that all information provided by me is true to the best of my knowledge. I understand if I have a change in income or assets, I must report that change to the county health department (CHD) within 90 days of that change. I understand that the CHD may verify the income information I provide. I understand that any intentional false or misleading statement by me can be charged as a second degree misdemeanor and will result in my loss of eligibility for this program.

Please mail my prescription to: _____ my home address above or _____ the CHD at _____

_____ _____ _____

Applicant Signature **Date**

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