



United Way-
Thomas Jefferson Area

RxRelief Program • Patient Information Form

Personal Information:

Name: _____ SS#: _____
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home) (Work) (Cell)

Sex: M / F DOB: ___ / ___ / ___ Marital Status: _____ # in household _____
(including yourself)

Ethnicity: _____ (optional)

Name of Spouse: _____ Spouse's SS#: _____

Income Information: *Income from ALL MEMBERS of the household must be included.*

Employment: \$ _____/month Pension: \$ _____/month

Social Security/Disability: \$ _____/month Spousal/Child Support: \$ _____/month

Other: \$ _____/month Source: _____

Insurance Information:

1. Did you file a tax return for the previous year? Y / N

2. Do you have Medicaid or Medicare Part A, B or D? Y / N

• If you circled YES, please list which one(s):

1. _____

3. Do you have medical insurance that covers prescriptions? Y / N

4. Are you currently enrolled in any drug companies' patient assistance program? Y / N

• If you circled YES, please list the medication:

1. _____

I HEREBY STATE THAT THE ABOVE IS ACCURATE AND I GIVE PERMISSION FOR THE ABOVE INFORMATION TO BE RELEASED TO ANY PHARMACEUTICAL COMPANY WITH REGARDS TO REQUESTS FOR DONATED MEDICATIONS.

Signature of Applicant: _____ Date: _____

Please fax to Brittani Meney, United Way - Thomas Jefferson Area: (434) 972-1719