



THE SENIOR SOURCE
SENIOR CITIZENS
OF GREATER DALLAS

Senior Prescription Assistance Intake Form

This form will assist low-income seniors in applying for free or low cost prescriptions through prescription assistance programs established by various pharmaceutical manufacturers. Client must be 55 years or older and reside in Dallas or Collin County.

Client Name _____
First Middle Last

Address _____

City _____ State TX Zip _____ Phone (____) _____ Ethnicity _____

Client Social Security Number _____ Date of Birth _____
Month, Day & Year

Client's Gender _____ Marital Status _____ Number in household _____
Single, Married, Widowed

Monthly household income _____ Source(s) of income _____
Social Security, SSI, Pension, VA, other

Total Liquid Assets _____
(Annuities, stocks, bonds, CDs, savings, 401K, secondary property)

Referral Source _____

Medical Coverage: (Include Medicare and Medicaid)

- _____
- _____

Prescription Coverage: (Include amount for co-pay, discount, generic only or none)

- _____
- _____

Please complete primary physician's information below. If you have more than one prescribing physician, please feel free to write information on back of this form.

Physician's name _____ Phone Number (____) _____

Address _____ City _____ State TX Zip _____

I understand that this information will be kept confidential and used only for program qualification. I hereby give permission to the Senior Prescription Assistance Program to provide the above information upon request to the appropriate physician or pharmaceutical company and/or request additional information regarding me from the appropriate physician or pharmaceutical company for the purpose of attaining free or low cost prescriptions. I also certify that the above information is complete and correct.

Client (or Legal Guardian) Signature _____ Date _____

Person filling out form _____
(Other than client) First Middle Last Phone

Privileged and Confidential: This information is confidential and intended only for those individuals on this form.



THE SENIOR SOURCE
SENIOR CITIZENS
OF GREATER DALLAS

Senior Prescription Assistance Intake Form For Medicare Beneficiaries

This form will assist low-income seniors in applying for free or low cost prescriptions through prescription assistance programs established by various pharmaceutical manufacturers. Client must be 55 years or older and reside in Dallas or Collin County.

Client Name _____
First Middle Last

Address _____

City _____ State TX Zip _____ Phone (____) _____ Ethnicity _____

Client Social Security Number _____ Date of Birth _____
Month/Day/Year

Client's Gender _____ Marital Status _____ Number in household _____
Single, Married, Widowed

Monthly household income _____ Source(s) of income _____
Social Security, SSI, Pension, VA, other

Total Liquid Assets _____
(Annuities, stocks, bonds, CDs, savings, 401K, secondary property)

Referral Source _____

Do you have Medicaid? Yes No

Medicare Part D Plan Name: _____

Are you in your coverage gap? Yes No
**The coverage gap is also known as "The Donut Hole." This occurs when you and your plan have spent a total of \$2510 on your prescriptions.*

Have you applied to the Social Security Administration's Extra Help program? Yes No
**The Extra Help Program helps pay for your Medicare Part D premium and co-pays.*

Medicare Card Information:

Medicare Number: _____

Effective Date for Part A: _____ Effective Date for Part B: _____

Please complete primary physician's information below. If you have more than one prescribing physician, please feel free to write information on back of this form.

Physician's name _____ Phone Number (____) _____

Address _____ City _____ State TX Zip _____

I understand that this information will be kept confidential and used only for program qualification. I hereby give permission to the Senior Prescription Assistance Program to provide the above information upon request to the appropriate physician or pharmaceutical company and/or request additional information regarding me from the appropriate physician or pharmaceutical company for the purpose of attaining free or low cost prescriptions. I also certify that the above information is complete and correct.

Client (or Legal Guardian) Signature _____ Date _____

Person filling out form _____
(Other than client) First Middle Last Phone

Privileged and Confidential: This information is confidential and intended only for those individuals on this form.

