CHARITABLE FOUNDATION

MEDICINE ASSISTANCE PROGRAM
PO BOX 1089
JONESBORO, AR 72403
PHONE: (870) 934-5400
FAX: (870) 934-3646

KEEP THIS PAGE FOR YOUR INFO

We appreciate your interest in the NEA Baptist Charitable Foundation Medicine Assistance Program. The information below is an outline of how the Medicine Assistance Program works. To qualify you must be within specific income guidelines set by each pharmaceutical company and be uninsured or underinsured.

1. **Please complete the attached information sheet entirely** and return by mail or fax.

2. **Proof of Household Income – Send whichever document applies to your household:**
   a. Copy of current Federal income tax return, pages 1 & 2. – *Form 1040*
   b. Copy of your Benefit Statement for this year from Social Security (*please contact your social security office to obtain information*)
   c. Proof of your monthly income from any other source, including pension, unemployment, employment, child support, etc.
   d. If "no income," please send a copy of HUD, SNAP, letter signed by family/friends for monetary gifts to help you meet your needs, or other benefits to show how you support yourself.

3. Please **send** a copy of the **front** and **back** of your insurance cards.

4. The Medicine Assistance Program will then review your medications and locate any programs available through the pharmaceutical companies. Forms from each pharmaceutical company will be mailed to you and your doctor. These forms will also need to be returned to the Medicine Assistance Program.

5. Once we have received all the forms, we will fax them to the pharmaceutical companies and wait for their decision. **The whole process can take 4 to 8 weeks**, so please be patient.

6. If approved, your medications will be sent to the doctor's office or your home, depending on the pharmaceutical company's preference. Once you start receiving your medications, call us **6 WEEKS** before you are out of medication to reorder. Most applications are good for one year. When an application expires, we will complete a new application to enroll you for another year.

PLEASE DO NOT SEND BANK STATEMENTS, UTILITY BILLS, OR MEDICAL RECORDS.

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MAP APPLICATION – COMPLETE EACH SECTION ENTIRELY

PLEASE DO NOT SEND MEDICAL RECORDS.

CONTACT INFORMATION

FIRST NAME ______________________________ MIDDLE ____________________ LAST ____

PHONE NUMBER HOME ________________ WORK __________________ CELL ________________ MESSAGE ________________

MAILING ADDRESS ____

CITY ____________________________________ STATE __________________________ ZIP CODE ___________

PERSONAL INFORMATION

DATE OF BIRTH ________________________ SOC. SECURITY NUMBER ______________________ MALE _____ FEMALE ______

US CITIZEN Y N US RESIDENT Y N US VETERAN Y N LEGALLY DISABLED Y N

MARITAL STATUS

MARRIED DIVORCED SINGLE WIDOWED

NUMBER IN HOUSEHOLD (INCLUDING THE PATIENT): ___________ RACE(OPTIONAL) ___________________

HOUSEHOLD INCOME – SEND PROOF OF INCOME FOR THIS YEAR – ACCEPTABLE DOCUMENTS INCLUDE:

FEDERAL 1040 TAX FORM

SOCIAL SECURITY BENEFITS STATEMENT OR LETTER

PENSION STATEMENT

UNEMPLOYMENT CHECK STUBS – 2 MONTHS WORTH

OTHER DOCUMENTS

IF YOU HAVE NO INCOME, SEND:

A LETTER STATING YOU HAVE NO INCOME, DATED AND SIGNED BY YOU
AND PROOF OF HUD/SNAP BENEFITS, OR OTHER BENEFITS TO SHOW HOW YOU SUPPORT YOURSELF

(REVISED JULY 8, 2019)

INSURANCE INFORMATION – SEND COPY OF FRONT AND BACK OF EACH INSURANCE CARD:
Check all that apply

_______MEDICARE _______ MEDICARE PART D DRUG PLAN ________LIS/EXTRA HELP

_______ MEDICAID _______PRIVATE INSURANCE

HEALTHCARE INFORMATION

MEDICAL CONDITIONS ____

____

____

DRUG ALLERGIES____

DOCTORS WHO PRESCRIBE YOUR MEDICATIONS:

NAME (first and last)	PHONE NUMBER	ADDRESS

(PLEASE DO NOT SEND MEDICAL RECORDS)

MEDICATIONS	STRENGTH/MG	# OF TIMES DAILY	CURRENT PRESCRIBING DR

PATIENT SIGNATURE____DATE____________________

BY SIGNING THIS APPLICATION YOU AGREE THAT ALL OF THE INFORMATION YOU HAVE PROVIDED IS CORRECT. YOU ALSO AGREE THAT YOU ARE RESPONSIBLE FOR REPORTING ANY CHANGES IN YOUR FINANCIAL SITUATION OR INSURANCE COVERAGE.