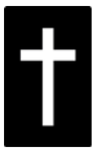

Saint Thomas Health

Saint Louise Pharmacy – Dispensary of Hope Rutherford

(Located 3 ½ miles from Saint Thomas Rutherford Hospital)
1020 North Highland Ave, Murfreesboro, TN 37130
Phone # 615-396-6167 Fax # 615-396-6627
Hours: M/T/W/T 8:30-5:30, Friday 8:30-1:00 (closed from 1-2 for lunch)
http://www.sthealth.com/medical-services/pharmacy-services/dispensary-of-hope

Patient Application

The following information is required for participation in the Dispensary of Hope Medication Assistance program.

First Name	Middle	Last	Social Security #

Mailing Address	City	State	Zip	County

Date of Birth	Age	Male/Female	Drug Allergies:

Home Phone	Work/Cell Phone

PLEASE BRING IN PROOF OF INCOME
DRUGS ON THE SAFETY NET LIST WILL COST YOU $1.00 or $3.00 PER PRESCRIPTION

Are you a US citizen or a legal US resident? Yes____ No ___
Did you File a Tax Return Last Year? Yes ___ No ___
Are you a Veteran? Yes ___ No ___
Do you receive Food Stamps? Yes ___ No ___
Do you have Medicare or Tenncare? Yes ___ No ___ (if yes, please list Medicare/Tenncare Number) ________________________
Has the Social Security Department classified you as disabled? Yes ___ No ___
Do you receive Social Security or Disability Benefits? Yes____ No ____
Do you have Prescription Drug Insurance? Yes ___ No ___ (please list) ____
What is your housing status? Rent ___ Own ___ Living with someone else ____ Other __________________________
Family Status Single ___ Married ___ Widowed ___ Divorced ___ Other: ____
Work status Employed ___ Retired ___ Disabled ___ Unemployed ___

How much before taxes do you earn or receive per WEEK __________ OR per MONTH ___________ OR per YEAR __________
(include wages, social security, pension, alimony, child support, unemployment, etc)
How many people are in the household? _________________________________
How much before taxes do other people in the household (including spouse) earn or receive?
per WEEK _____________ OR per MONTH _____________ OR per YEAR _______________

Name of Physician (s)	MD phone number	MD Fax # (if known)

Thank you for your information. It will be held securely and will not be shared with anyone who is not involved with the medication assistance programs or your health status.

YOU WILL BE ASKED TO BRING or SEND PROOF OF INCOME WITHIN TWO WEEKS OF APPLICATION, ANY TAX RETURNS FOR THE PAST YEAR AND A COPY OF ANY INSURANCE CARDS (BOTH MEDICAL AND DRUG CARDS) AT THE TIME OF YOUR APPOINTMENT OR WITHIN THE FIRST 30 DAYS. WE MUST HAVE PROOF OF INCOME TO PROVIDE ASSISTANCE BEYOND THE INITIAL 30 DAYS. (Proof of income and application must be provided every 6 months)

The information above that I have provided is correct and complete. I understand that if I provide falsified information, that enrollment in the Dispensary of Hope program will be revoked.

____ ______________ ***Rev 12/09/16***
Signature of patient Date

Office use only

Date of Application ______
Initials _____ Total Household Income _________________Number in Household _______________
% assistance provided ________ (Source of Referral) SS MD STFHCW ROOM OTHER _________________________
Notes: