Saint Thomas
MIDTOWN HOSPITAL

Saint Vincent Pharmacy– Dispensary of Hope Midtown
(Located inside Saint Thomas Midtown Hospital)
(1st Floor Next to Admissions)
2000 Church Street, Nashville, TN 37236
Phone # 615-284-6170 Fax # 615-284-6171
HOURS: M/T/W/F 9-4, Thurs 10-4 (closed for lunch 1-2)
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 <u>before taxes</u> 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 <u>before taxes</u> 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 <u>WITHIN TWO WEEKS OF APPLICATION</u>, 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. <u>WE MUST HAVE PROOF OF INCOME TO PROVIDE ASSISTANCE BEYOND THE INITIAL 30 DAYS.</u> (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: