



Saint Thomas
WEST HOSPITAL

Plaza Pharmacy - Dispensary of Hope West

(Located inside Saint Thomas West Hospital)

(Plaza West Medical Building)

4230 Harding Road, Suite A214, Nashville, TN 37205

Phone # 615-222-6216 Fax # 615-222-6189

HOURS: Mon-Fri 8am-4pm

<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:

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

Home Phone Work/Cell Phone

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: