Dear Applicant,

Thank you for your interest in the NC MedAssist prescription assistance program. NC MedAssist is a statewide non-profit pharmacy that provides free prescription medications to qualified North Carolinians.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information provided is correct.

Patient eligibility:

- Must be a North Carolina resident
- Household income must be at or below 200% of the Federal Poverty Guidelines
- Cannot have Medicare, Medicaid, VA benefits or any other prescription drug insurance

To apply, please send ALL of the following documents TOGETHER to NC MedAssist:

1. Application for NC MedAssist completed and **signed**
2. **Original prescription (bottles, lists, copies and transfers are NOT acceptable forms of a prescription)**
3. Proof of residency. State ID with **current** address or utility bill or medical bill
4. Proof of current income. Examples include:
   - If working, a month's worth of consecutive pay stubs dated within the last 60 days for the entire household (four pay stubs if paid weekly, two if paid bi-weekly, etc.)
   - If you are receiving VA benefits, workers comp, or short term disability, we will need proof of what you are receiving in the current year
   - If you have Retirement/Pension income, we need a statement for the current year
   - If you have Social Security – Your new benefit amount letter for **current** year **(form 1099 not accepted)***
   - If you have Social Security Disability income, we need **"Notice of Awards"** letter and current year statement*
   - If you are unemployed, we need Proof of Employment Security Commission unemployment benefits*
5. If unemployed with no source of income, please have support letter signed by the person providing you financial support and/or room and board
6. The first two pages of the current year federal income tax return (1040). Please include your spouse's return if married. If you are self-employed please attach the schedule C along with your tax return. **Please sign your tax return**
   - If you did not file taxes, please sign a 4506T form (this form can be acquired at our office or at www.irs.gov)

SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:

- **MAIL**: NC MedAssist, 4428 Taggart Creek Road, Suite 101, Charlotte, NC 28208
- **FAX:** 1-704-536-9865

Enrollment in program is for up to one (1) year and you are eligible for all medications on the NC MedAssist formulary. You are responsible for renewing your application annually before your original enrollment date.

Medications will be shipped as designated on the application; either to a Point of Entry (POE) or your home. You may request a refill up to 10 days before prescription(s) runs out. If you have any questions or need further assistance, please call (866)331-1348 or visit the website at www.medassist.org.

*If you do not have your Social Security statements, they can be obtained at your local Social Security office.

4428 Taggart Creek Road, Suite 101
Charlotte, NC 28208
Toll Free: (866) 331-1348
Local: (704) 536-1790
Fax: (704) 536-9865

ENROLLMENT APPLICATION

For office Use Only
Date Entered______________ Temp Date______________ Recert Date______________ POE_____________

First Name:	MI:	Last Name:	Social Security Number:	Birth Date:
Mailing address:	City:		State:	Zip:
Email Address:			Primary Phone #:	Secondary Phone #:
Emergency Contact *(name other than applicant):*			Emergency Contact Phone #:	
North Carolina County of Residency:			Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated	
Name of Healthcare Provider or Doctor:			Doctor's Phone #:	

Do you smoke? ☐ Yes ☐ No If yes, are you interested in quitting? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If yes, list: ____

How did you hear about the NC MedAssist program? _________________

Ethnicity:	**Primary Language Spoken:** *(other than English)*	**Gender:**	**Number of People in Household:** *(including self)*
☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Indian ☐ Other	_______________________	☐ Male ☐ Female	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Other _____

List and Attach all Household Income:		Do you have any of the following forms of Insurance?	
Salary/Wages	$_________________	Health Insurance	☐ Yes ☐ No
Disability	$_________________	Medicare	☐ Yes ☐ No
Alimony/ Child Support	$_________________	Medicare Part D	☐ Yes ☐ No
Social Security	$_________________	Medicaid	☐ Yes ☐ No
Pension/Retirement	$_________________	Family Planning	☐ Yes ☐ No
Unemployment/Work Comp	$_________________	VA Health	☐ Yes ☐ No
Gross Monthly Income	**$**_________________		
Total Gross Annual Income	**$**_________________		

Applicant's Agreement/Disclosure/Release

I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, services are not guaranteed. By signing this application I release NC MedAssist, its affiliated drug companies and any public or private agencies or financial supporters and their agents from any and all claims of liability in contract or tort arising out of the actions of NC MedAssist, its agents, employees, or P.O.E in performing services or related to services I receive from NC MedAssist. I give my consent to DSS and DHHS to advise NC MedAssist of the status of a pending Medicaid application. I will promptly notify NC MedAssist if I become eligible for Medicare, Medicaid, private insurance or VA benefits, or if my income changes. I also give consent to NC MedAssist to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state and local laws and regulations and purposes directly related to the administration of NC MedAssist programs and grants. I have received NC MedAssist's Notice of Privacy Practices Statement. I give my permission to NC MedAssist to sign my name on Patient Assistance Program documents when necessary.

I authorize NC MedAssist to ship my medications to the Sponsoring Point of Entry ______________________________
Enter name of Sponsoring Point of Entry

Name of Enrollment Site (if applicable)____
This line is intended for the enrollment site only

Applicant's Signature____ Date____________________

NC MedAssist Employee's Signature____ Date____________________