

Dear Sir or Madam:

Thank you for your interest in the SenioRx Program. You will find the SenioRx application that you requested attached. **Please complete the application and mail it back to the address below.**

**Attn: Deborah Jones  
AIDB Senior Services  
P.O. Box 698  
Talladega, AL 35161**

**Please call **Deborah Jones at 256-761-3640, if you have any questions.****

# PRESCRIPTION DRUG ASSISTANCE



## APPLICATION INSTRUCTIONS

**Thank you for allowing us to help you with your medication needs. We hope this service will be of great benefit to you. We look forward to working with you. Please carefully follow all directions on the application and include all information needed when you mail it back to us. This will help us to serve you in a more efficient manner. Failure to do so may delay the process.**

**Please attach copies of the following documents with your application:**

1. A copy of your Medicare Card, Social Security Card and driver's license or photo identification.
2. Social Security Benefit Letter for the **current calendar year** for everyone in the house who receives benefits.
3. **A list of your present medications from your pharmacy including dosage information and cost per prescription, - please clearly list all medications you need help with on the back of your application. This is very important.**
4. All insurance proof (Medicare, Blue Cross, QMB Medicaid, Part D, other insurance)
5. Income proof for EVERYONE who lives in your house.
6. CURRENT pension or retirement benefits letters.
7. A copy of the last three paycheck stubs for everyone living in your home that is working.
8. Proof of any other income, such as: Annuities, stocks, bonds, CD's, savings accounts, IRA's, interest income.

**This information will be kept STRICTLY CONFIDENTIAL and will expedite the application process and allow us to serve you in the future.**



**For more information, contact:  
SENIORx  
Partnership for Medication Access  
1-800-AGE-LINE (243-5463)**



Administered statewide by the Department of Senior Services through 13 Area Agencies on Aging that provide a variety of services for all Alabamians over the age of 60.



# Alabama Department of Senior Services

## SenioRx

### FY24 Participant Enrollment Form

Please complete and return to your Area Agency on Aging (AAA). Call **1-800-AGELINE (1-800-243-5463)** for the correct mailing address.

<b>PARTICIPANT INFORMATION: Shaded area required for ADSS. Other information as required by medication assistance programs.</b>		
Last Name:	First Name:	MI:
Street Address:		Mailing Address (If different):
City:	State:	Zip:
City:	State:	Zip:
County:	Home Phone: ( )	Other Phone: ( )
Email address:		
Birthdate: ____/____/____ MM DD YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Race:</b> <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian <input type="checkbox"/> African-American/Black <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Other	<b>Ethnicity:</b> <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino	
Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> <b>Dementia-related diagnosis</b>
<b>Income Range:</b> Is your gross monthly income above \$1,215 <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>EMERGENCY CONTACT INFORMATION:</b> Please provide name of a person to contact in an emergency.		
Name: _____	Relationship to participant:	
Home Phone: _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative	
Work Phone: _____	<input type="checkbox"/> Friend <input type="checkbox"/> Neighbor	
Cell Phone: _____		
Primary Physician:	Physician Phone:	
Social Security #:	Medicare #:	
Are you a legal resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Employment Status:</b> <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		Are you a veteran or veteran's spouse/widow? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Not Married <input type="checkbox"/> Widowed		Number living in household (including client):
		Spouse's Birthdate: ____/____/____
		Spouse's Name:
		Spouse's Social Security #: ____-____-____
<b>SOURCES OF INCOME</b> We <b><u>MUST HAVE</u></b> a copy of proof(s) of income for EVERYONE who lives in your household. <b>TOTAL MONTHLY INCOME \$</b> _____ <b>TOTAL ANNUAL INCOME \$</b> _____ Salary/Wages \$ _____      Unemployment \$ _____      Social Security Disability \$ _____ Veteran's Benefits \$ _____      Child Support \$ _____      Social Security \$ _____ Workman's Comp \$ _____      Pension \$ _____      SSI \$ _____ Railroad Retirement \$ _____      Interest Income \$ _____      Other \$ _____		
<b>Attach copies of W2 form(s), tax return(s), bank statement(s),            Social Security benefit statement(s), or other sources of income</b>		

**MEDICAL INFORMATION**

Are you currently enrolled in another prescription assistance program or discount program?  Yes  No

Are you enrolled in:  Medicare  VA Benefits  SLMB  QMB  QI-1

Do you have any health insurance coverage (other than Medicare)? \_\_\_\_\_

Company Policy #

Do you have a Medicare Supplemental Policy?

Company Policy #

Medical Conditions:  Heart  Asthma/COPD  B/P  Gastrointestinal  
 (Check all that apply)  Cholesterol  Dementia  Mental Health  Glaucoma

Medication Allergies:  None  Sulfa  Penicillin  Codeine  
 (Check all that apply)  Iodine  Other  Aspirin

**If you have more than one prescribing physician, please attach a list with each doctor's name, address, and telephone number.  
 Alabama SenioRx cannot guarantee that you will receive the medicines requested.**

Medication	Dosage	Name, Phone Number, and Address of Prescribing Doctor	Cost per month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I hereby state that the information I have given is correct to the best of my knowledge and the **Alabama SenioRx** program has my permission to obtain and release information as deemed necessary to obtain my medication. I understand the **Alabama SenioRx** program cannot guarantee assistance. I understand that omitting or falsifying information is grounds for denial of services.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Statement of Confidentiality:** The information recorded on this form is required for the statistical and reporting requirements for State and Community Programs under the Older Americans Act of 1965, as amended [Public Law 8973], and is not to be used for any other purpose in any form which could identify the individual without the individual's knowledge of the specific use and the individual's specific authorization for such use.



## PATIENT CONSENT AND RELEASE FORM

I give permission to authorized representatives of the AIDB SenioRx to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize SenioRx to discuss my medical needs and me with my physician when necessary. Additionally, I give SenioRx permission to verify my income through the Alabama Department of Human Resources, Social Security Administration, my employer, Veterans Administration and/or any other company, business or organization from which I receive income. This authorization is good as long as SenioRx is assisting me or until I revoke such in writing.

***I want a copy of this form to be accepted as a valid consent to share information.***

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

NAME (please print) \_\_\_\_\_ BIRTHDAY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

COUNTY: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

## PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of SenioRx Foundation to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as SenioRx is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_