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: Kathy Gaines
P.O. Box 1444
Anniston, AL 36202

Please call Kathy Gaines at 256-237-8355, if you have any questions.

PRESCRIPTION
DRUG ASSISTANCE

SENIORx
Partnership for Medication Access
1-800-AGE-LINE (243-5463)

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
FY26 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.

PARTICIPANT INFORMATION: Shaded area required for ADSS. Other information as required by medication assistance programs.					
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:** ☐ Male ☐ Female	**Ethnicity:** ☐ Not Hispanic/Latino ☐ Hispanic/Latino	
Race: ☐ Caucasian/White ☐ Asian	☐ African-American/Black ☐ Native Hawaiian		☐ Alaska Native ☐ Pacific Islander	☐ American Indian ☐ Other	
EMERGENCY CONTACT INFORMATION: Please provide name of a person to contact in an emergency.					
Name: Home Phone: Work Phone: Cell Phone:			**Relationship to participant:** ☐ Spouse ☐ Neighbor ☐ Friend ☐ Other ☐ Relative		
Primary Physician:			Physician Phone:		
Social Security #:			Medicare #:		
Are you a legal resident of the U.S.? ☐ Yes ☐ No			☐ Dementia-related diagnosis		
Employment Status: ☐ Retired ☐ Disabled ☐ Full Time ☐ Part Time			Are you a veteran or veteran's spouse/widow? ☐ Yes ☐ No Number living in household (including client):		
Marital Status: ☐ Married ☐ Not Married ☐ Widowed			Spouse's Birthdate: Spouse's Name: Spouse's Social Security #:		

SOURCES OF INCOME: We MUST HAVE a copy of proof(s) of income for EVERYONE who lives in your household.

TOTAL MONTHLY INCOME $			**TOTAL ANNUAL INCOME $**		
Salary/Wages	$	Unemployment	$	Social Security Dis.	$
Veteran's Benefits	$	Child Support	$	Social Security	$
Workman's Comp	$	Pension	$	SSI	$
Railroad Retirement	$	Interest Income	$	Other	$

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 #
Medical Conditions: (Check all that apply)	☐ Heart ☐ Cholesterol ☐ Diabetes	☐ Asthma/COPD ☐ Dementia ☐ B/P	☐ Mental Health ☐ Gastrointestinal ☐ Glaucoma
Medication Allergies: (Check all that apply)	☐ None ☐ Iodine ☐ Sulfa	☐ Penicillin ☐ Other	☐ Aspirin ☐ Codeine

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.

AUTHORIZATION CONSENT AND RELEASE FORM

I give permission to authorized representatives of the Interfaith Ministries SenioRx Prescription Assistance Program 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/or prescription needs with my physician and pharmacist when necessary. Additionally, I give the SenioRx program permission to verify my income through the Alabama Department of Human Resources, Social Security Administration, Veteran's Administration, my employer, 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 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 myself that they need.

I authorize representatives of SenioRx 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. The signature authorization is good as long as SenioRx is assisting me or until I revoke such.

NAME (please print): _____ BIRTHDATE: _____

ADDRESS/P.O.: _____

CITY/STATE/ZIP: _____

COUNTY: _____

PHONE: _____

EMAIL: _____

SIGNATURE: _____ DATE: _____

A copy of this document shall be as valid as the original.