ALABAMA SENIOR RX

CLIENT INTAKE FORM

_____
AIMS CLIENT NUMBER (office use)

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

Social Security #: _____ Medicare #: _____ County: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ Race/Ethnicity: ___ White ___ African American ___ Other

Street Address: _____ Birthdate: _____/_____/_____ Gender: ___ Male ___ Female

City/Zip: _____ Home Phone: ( ) -

Did you file income taxes last year? Yes No

Are you a legal resident of the U.S.? Yes No

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 #: _____

Primary Physician: _____
Name Address Phone

Emergency Contact: _____
(Not living with you) Name Phone Relationship

SOURCES OF INCOME

(We MUST HAVE a copy of proofs of income for EVERYONE who lives in your household.)

TOTAL MONTHLY INCOME $ _____ **TOTAL ANNUAL INCOME $** _____

Salary/Wages $ _____	Unemployment $ _____	Social Security Disability $ _____
Veteran's Benefits $ _____	Child Support $ _____	Social Security $ _____
Workman's Comp $ _____	Pension $ _____	SSI $ _____
Railroad Retirement $ _____	Interest Income $ _____	Other $ _____

(Attach copies of W2 forms, tax returns, bank statements, social security benefits statements, or other sources of income.)

TOTAL AMOUNT OF ASSETS $_____
For example: any bank accounts, investments, 401K, property you own (other than the house you live in)

TOTAL AMOUNT OF EXPENSES $_____
For example: mortgage or rent, utilities, insurance (not health insurance)

TOTAL MEDICAL EXPENSES $ _____
(For example: Over-the-counter medicines, health insurance,premiums, copays, medical supplies, doctor & hospital visits, lab fees)

PRESCRIPTION DRUG COSTS $_____
(a monthly average)

The Alabama Department of Senior Services, through 13 Area Agencies on Aging, administers this statewide program.
The information being collected will be kept STRICTLY CONFIDENTIAL

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 #

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

Medication	Directions/ Strength	Name, phone number and address of prescribing doctor	Cost per Month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medical Conditions: (please circle) Heart Asthma High BP Ulcer Glaucoma

Other: _____

Medication Allergies: (please circle) None Sulfa Penicillin Aspirin Codeine Iodine

Other: _____

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

Signature: _____ Date: _____