_____
AIMS CLIENT NUMBER (office use)

ALABAMA SENIOR Rx/WELLNESS
CLIENT INTAKE FORM

ATRC SenioRx, 107 Broad St., Camden, AL 36726
Call **1-800-617-0500 OR 334-682-5206**

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

Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____ Race/Ethnicity: White: _____ African American:_____ Other_____

Street Address:_____ Birthdate: ____/____/____ Gender: Male _____ Female_____

City/State/Zip: _____ Home Phone: (___)____-_____ email: _____

Did you file income taxes last year? Yes ___ No___
Please attach a copy if yes

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: _____
Name Address Phone

SOURCES OF INCOME

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

(Please attach copies of W2 forms, tax returns, bank statements, Social security benefits statements, or other sources of income.)

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	$_____

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

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

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

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? Yes _____ No _____
Do you have a Medicare Supplemental Policy? _____
Company Policy #

Do you have a Medicare Part D Plan?
_____
Company Policy#

Do you receive Low Income Subsidy (LIS)? Yes _____ No_____

Medication	Directions/Strengths	Name, phone number, and address of prescribing doctor	Cost per month
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

Medical Conditions: (please circle) Heart High BP Diabetes Asthma COPD 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 information is grounds for denial of services.

Signature: _____ Date:_____