



# Regional One Health

## Patient Assistance Program Application

### Personal Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 SSN \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Drug/Food Allergies \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Employer Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Marital Status:  Single  Married  Divorced  Widowed  Separated  Other

### Spouse/Other Information:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Spouse SSN \_\_\_\_\_ Spouse Date of Birth \_\_\_\_\_  
 Spouse/Other Employer \_\_\_\_\_

### Monthly Gross Household Income Information:

For You \_\_\_\_\_ For Spouse \_\_\_\_\_ For Other \_\_\_\_\_  
 Number of Dependents \_\_\_\_\_ Age(s) of Dependents \_\_\_\_\_  
 Are you employed?  Yes  No  Full time  Part time  Retired  Other  
 Did you file income tax in 20\_\_?  Yes  No Are you a veteran?  Yes  No  
 Do you receive Food Stamps?  Yes  No If so, how much \_\_\_\_\_

### Insurance Information:

Will any of these charges be handled by an attorney?  Yes  No  
 Do you have Medical Insurance?  Yes  No  
 Do you have Medical Insurance/Medicare/Medicaid that pays for your medications?  
 Yes  No

Name of Insurance	Insurance/Medicare ID Number	Have you applied for?			What were the results?		
TennCare	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	
Medicaid	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	
Social Security	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	
Disability	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	
Crime Victim's Comp.	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	
Workman's Comp.	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Pending	

*I am requesting that consideration be given to me by Regional One Health for Uncompensated Care and/or reduced cost medications. I understand that the information which I submit concerning my annual income and family size is subject to verification by Regional One Health. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of services provided as uncompensated and/or reduced cost medications, and I will be liable for charges incurred. Furthermore, I am aware that this is a voluntary service by Regional One Health, and they maintain exclusive rights to approval or denial.*

*I affirm that the information provided is true and correct to the best of my knowledge.*

Signature \_\_\_\_\_

Date \_\_\_\_\_