(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

# OUTPATIENT PHARMACY

## Medication Assistance Program (MAP)

### Patient Information

Full Name: _____ Date of Birth: _____
*Last* *First* *Middle*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone: _____ Email: _____

### Insurance

| | | | |
|---|---|---|---|
| Do you have prescription/pharmacy insurance? | ☐ YES | ☐ NO | ☐ UNSURE |
| Do you have Arkansas Medicaid? | ☐ YES | ☐ NO | ☐ UNSURE |
| Do you have Medicare A and/or B (hospital/medical)? | ☐ YES | ☐ NO | ☐ UNSURE |
| Do you have Medicare Part D (prescription/pharmacy) or Medicare Advantage? | ☐ YES | ☐ NO | ☐ UNSURE |
| Have you applied for Medicare low-income subsidy (LIS) or "extra help"? | ☐ YES | ☐ NO | ☐ UNSURE |

### Household Income

How many people live in your household? _____

For each member of your household, provide the following information:

| Full Name | Date of Birth | Total Income *(from all sources, before taxes/deductions)* |
|---|---|---|
| | | $ Yearly/Monthly (circle one) |
| | | $ Yearly/Monthly (circle one) |
| | | $ Yearly/Monthly (circle one) |
| | | $ Yearly/Monthly (circle one) |

### Required Documentation

***At least one of the following:*** Social Security award letter for the current calendar year; Current W-2 or 1099 forms; Last 3 consecutive pay stubs; Pension statement; Last 3 consecutive bank statements; Unemployment letter
Other proof of income (must be preapproved with MAP office)

### Disclaimer and Signature

*I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in immediate dismissal from the program. I acknowledge that I have read, understand, and agree to the policies and procedures of the MAP program.*

Signature: _____ Date: _____