



Avenues to Medicine, Ltd. Co. - Client Application Form

Each individual must submit an application - please make additional copies if needed

Contact Information

Name		Home Phone	
Address		Work Phone	
City			
State		Gender	Male Female
Zip		Birth Date	
County/Parish		Social Security #	
Marital Status	Married Single Separated Divorced Widowed	# of Dependents	
If Married	Is Spouse currently participating in our program? Yes No If no, would Spouse like to participate in our program? Yes No	Spouse Name	
Did you file a tax return last year?	Yes No	# of People in Household including Self	
Caregiver Name <i>(optional)</i>		Caregiver Phone <i>(optional)</i>	

Insurance Coverage

Identify if you currently have any of the following coverages:

Medicaid Prescription? Yes No	Medicare Supplement? Yes No	Prescription Insurance? Yes No
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Income Sources

- **If Married – is your annual gross income \$24,000 or less (\$2,000 monthly)?** Yes No
- **If Single – is your annual gross income \$16,000 or less (\$1,300 monthly)?** Yes No

	Self Income	Spouse Income	Total Household Income
Monthly Salary/Wages			
Monthly Retirement/Pension Benefits			
Monthly Social Security			
Monthly Social Security Disability			
Monthly Unemployment Compensation			
Other – Please identify any additional sources of income			

Note: Income levels vary by pharmaceutical company and may be higher or lower than indicated above. Income can be higher for certain medical conditions including HIV, Cancer or MS; or if you have dependents. You will qualify for free medications if you have any of the following: Medicare A and B, a Medicare supplement, a Prescription Discount Card (e.g. AARP & Together RX), or if you participate in an HMO that pays only for generic medications.

IMPORTANT! You MUST enclose copies of any of the following proof of income documentation: Social Security Awards Letter (SSA); Social Security Benefits Statement, W-2s, and/or a copy of the first page of your previous year's tax return.

Medication List

	Name of Medication	Strength	Qty per Day	Cost/ Frequency	Doctor's Name
Example	Synthroid	40 mgs	3	\$160/month	Joseph Jones
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Doctor Contact List

For each Doctor identified in the Medication List above please complete contact information:

	Doctor's Name	Doctor's Address	Telephone #
Example	Joseph Jones	1234 Elm Street, Suite 200 West Hartford, CT 06110	123-456-7890
1			
2			
3			

I understand that:

1. I may not qualify for all medications listed above and that each individual pharmaceutical company makes the final decision as to whether an applicant qualifies for assistance.
2. This application only initiates the administrative process with the Avenues to Medicine, Ltd. Co. program. Please **DO NOT** enclose prescriptions with this application.
3. The application fee is non-refundable unless it is determined I am ineligible for the free medication program.
4. It normally takes 2-5 weeks (but could take up to 10 weeks) after my doctor finalizes my pharmaceutical applications to receive my free medications.

Signature of Applicant: _____ Date: _____

**Mail Completed Application, Copies of Income Documentation and
\$25 Processing Fee per application to:**

Avenues to Medicine, Ltd. Co., P.O. Box 151, Seymour, CT 06483



Questions or need help? Call Toll-free, 877-788-5644