

ALABAMA SENIOR R_X

CLIENT INTAKE FORM

AIMS CLIENT NUMBER (office use)

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

Social Security #:	Medicare #:		County:					
Last Name:	First Name:		MI:					
Mailing Address:								
	Birthdate:/ Gender: Male Female							
City/Zip: Home Phone: () -								
Did you file income taxes last year?	Yes No Are y	ou a legal resident of the	U.S.? Yes No					
Employment Status: ——Retired	—— Disabled	Are you a veteran or veteran's spouse/widow? Yes No						
—— Full time	——— Part time	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.)								
TOTALMONTHLYINCOME \$.	LYINCOME \$ TOTALANNUAL INCOME \$							
Salary/Wages \$	_ Unemployment \$ _		curity Disability \$					
	Child Support \$ Social Security \$							
Workman's Comp \$		SSI \$ Other \$						
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 \$		TOTAL MEDICAL EXPENSES \$						
For example: any bank accounts, investments, 401K, property you own (other than the house you live in)		(For example: Over-the-counter medicines, health insurance, premiums, copays, medical supplies, doctor & hearital vicita, lab fees)						
TOTAL AMOUNT OF EXPENSES	\$	hospital visits, lab fees)					
For example: mortgage or rent, utilities, insurance (not health insurance)		PRESCRIPTION DRUG COSTS \$(a monthly average)						

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 Po			licy#				
*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 Co			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 cir	rcle) 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:									