Abbeville GENERAL
ACCESS TO QUALITY CARE CLOSE TO HOME

118 North Hospital Drive
P.O. Box 580
Abbeville, Louisiana 70511-0580
Voice: (337) 893-5466
Fax: (337) 893-2801

AGH Clinic
Maurice Clinic
Erath/Delcambre Clinic
2419 Alonzo, Abbeville, LA 70510
207 Milton Road, Maurice, LA 70555
220 North Road, Erath, LA 70533

Required for Pharmaceutical Assistance:

1. **Yearly membership fee=$30.00**

2. **Previous month's proof of income. Example-paycheck stubs, letter from employer stating gross monthly income, copy of social security income letter or check or rental income receipts.**
3. **Previous year's Federal income tax returns (1040's).**
4. **Most Pharmaceutical Companies require a picture ID.**

02/18/2016

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PHARMACEUTICAL ASSISTANCE INFORMATION FORM

NAME: _____ **DATE:** _____

ADDRESS: _____

PHONES: (H) _____ **(W)** _____ **(C)** _____

DATE OF BIRTH: _____ **GENDER:** _____

EMERGENCY CONTACT: _____

ALLERGIES: _____

HEALTH CONDITIONS: _____

SSN#: _____ **#HOUSEHOLD** _____

TOTAL MONTHLY INCOME: _____

SOURCE OF INCOME: _____

INSURANCE COVERAGE: _____

MARITAL STATUS: _____

EMPLOYMENT STATUS: _____

PHYSICIANS'S NAME: _____

EMAIL ADDRESS: _____

LIST OF MEDICATIONS & DOSAGE:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

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PATIENT CONSENT AND RELEASE FORM

I give permission to authorized representatives of Abbeville General Hospital/Maurice/Erath/Delcambre Community Care Clinics to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize Abbeville General Hospital/Maurice/Erath/Delcambre Community Care Clinics to discuss my needs with my physician when necessary. Additionally, I give Abbeville General Hospital / Maurice/Erath/Delcambre Community Care Clinics permission to verify my income through the Social Security Administration, my employer, Veterans Administration or any other company, business or organization from which I receive income. This authorization is good as long as Abbeville General Hospital/Maurice/Erath/Delcambre Community Care Clinics is assisting me or until I revoke such.

I want a copy of this form to be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

DOB: _____ SSN#: _____

ADDRESS: _____

FULL (PRINTED) NAME OF PATIENT: _____

Signature: _____ DATE: _____

Patient Signature Authorization

I authorize representatives of Abbeville General Hospital/ Maurice/Erath/Delcambre Community Care Clinics to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as Abbeville General Hospital/Maurice Community Care Clinics is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: _____

Signature: _____ DATE: _____

The information being collected will be kept strictly confidential.