

Date Received \_\_\_\_\_

Code: \_\_\_\_\_

**CLIENT PRE-QUALIFYING APPLICATION  
AFFORDABLE PRESCRIPTION PROGRAM**



**PLEASE PRINT CLEARLY**

**WORLD MEDICAL RELIEF, INC.**

21725 Melrose Ave., Southfield, MI 48075, 313-866-5333, Fax: 313-866-5588

[www.worldmedicalrelief.org](http://www.worldmedicalrelief.org)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: S \_\_\_\_ M \_\_\_\_ D \_\_\_\_ Sep \_\_\_\_ W \_\_\_\_

US Citizen: Yes \_\_\_\_ No \_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_ Disabled: Yes \_\_\_\_ No \_\_\_\_ Hd. of Hshd. \_\_\_\_

Employment Status: Retired \_\_\_\_ Unemployed \_\_\_\_ Working full time \_\_\_\_ Working part time \_\_\_\_

Emergency contact person \_\_\_\_\_ Contact phone # \_\_\_\_\_

**LIST ALL YOUR PRESCRIPTIONS**

MEDICATION	STRENGTH	FREQUENCY (ex: Take once daily)

Do you have any insurance coverage that pays for all or part of your prescription medication: Yes \_\_\_\_ No \_\_\_\_  
(Private insurance, Medicaid, Medicare supplemental, VA medical benefits, AIDS drug assistance, state or local programs)

**Monthly Household Income (If married, include both husband and/or wife)**

Net wages	\$	Tax stmt-1040	\$	Alimony	\$
Soc. Security	\$	Pension	\$	Food Stamps	\$
S.S. Disability	\$	Medicaid	\$	Other	\$
Unemployment	\$	Bridge Card	\$	Total Income	\$

**For this application to be approved, you must include documentation of your monthly household income: pay stub, unemployment information, pension information, copy of bridge card, etc.**

The above information is correct to the best of my knowledge \_\_\_\_\_

**Signature and date**

**Please complete all the forms.**

Revised 12/3/19

How did you hear about the Affordable Prescription Program?

---

Because this organization receives federal funding intended for low and moderate-income households in the City of Detroit, the indicated information is requested for statistical reporting purposes. Racial breakdowns are required for federal reporting purposes. Please check only one of the listed categories.

Hispanic or Latino	
NOT Hispanic or Latino	
White	
Black or African American and White	
Black or African American	
Asian	
Asian and White	
Native Hawaiian or Other Pacific Islander	
American Indian or Alaska Native	
American Indian or Alaska Native and Black African American	
American Indian and White	
*Other multi-racial category: List	

Don't forget to include proof of your income and a copy of your ID. Make sure you sign and date the application and the Privacy form. Complete the questionnaire to the best of your ability.

On Page 1 – Head of Household means a woman with a child/children under the age of 18.

Are you a diabetic? Yes\_\_\_\_ No \_\_\_\_

Do you use insulin? Yes\_\_\_\_ No \_\_\_\_ Do you take diabetic medication by mouth? Yes\_\_\_\_ No \_\_\_\_

Are you applying to this program for assistance with your diabetic medication? Yes \_\_\_\_ No \_\_\_\_

Would you like further information on diabetes and wellness programming? Yes\_\_\_\_ No \_\_\_\_



Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that World Medical Relief comply with certain rules regarding maintaining privacy of your medical information that we have collected and will collect in the future. This applies to the information you provided World Medical Relief when you applied for the Affordable Prescription Program as well as information regarding the prescriptions we are receiving and filling for you from your physician.

Existing Michigan law requires us to obtain, or attempt to obtain, your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a court order as part of a criminal investigation; or a licensure investigation.

From time to time it may be necessary for us to make disclosure of your information.

### **PATIENT ACKNOWLEDGEMENT**

*Please sign this form below under the heading "acknowledgement" that you have today received a copy of our notice of privacy practices.*

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Patient Name (please print)

Date \_\_\_\_\_

### **PATIENT CONSENT**

*Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with the proper services of the Affordable Prescription Program.*

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Patient Name (please print)

Date \_\_\_\_\_





## WORLD MEDICAL RELIEF AFFORDABLE PRESCRIPTION PROGRAM

### ENROLLMENT SURVEY

Please answer all questions to the best of your ability. We cannot process your application unless the survey is completed.

1. I spend \$\_\_\_\_\_ per month for my prescription medicines. (Please include the total)

How often are you able to pay for all of your prescriptions each month? (Circle answer that applies).

Always      Almost Always      Sometimes      Rarely      Never

If you are not able to pay for all of your prescriptions each month, please complete the following:

Each month I have \$\_\_\_\_\_ in uncovered prescription cost.

2. How often do you worry about having enough money to buy prescription medication?

Always      Almost Always      Sometimes      Rarely      Never

3. How often do you have to make a choice between buying prescription medication and paying bills?

Always      Almost Always      Sometimes      Rarely      Never

4. Please rate how easy it is to manage your health problems: (Circle the answer that applies)

Very Easy      Somewhat Easy      Somewhat Difficult      Very Difficult

5. On a scale of 1 to 5, - with one being the lowest – please rate your energy level:

1      2      3      4      5

6. Please rate how healthy you feel:      1      2      3      4      5

7. Please rate how active you feel:      1      2      3      4      5

8. If I need to go to the drug store, see a doctor or dentist, or participate in other medical appointments, I can get there on my own without help from family or a caregiver.

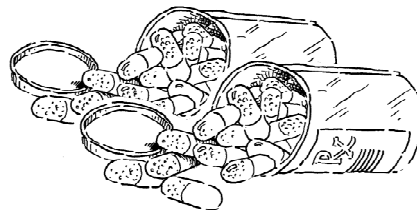
Yes \_\_\_\_ No \_\_\_\_

9. I usually must rely on family or a caregiver to help me get to my medical appointments or the drugstore.

Yes \_\_\_\_ No \_\_\_\_

NAME \_\_\_\_\_ CITY \_\_\_\_\_ DATE \_\_\_\_\_

**DO YOU OR SOMEONE YOU KNOW  
NEED HELP WITH PRESCRIPTION  
DRUGS?**



**WORLD MEDICAL RELIEF'S  
AFFORDABLE PRESCRIPTIONS PROGRAM  
MAY BE THE ANSWER!**

**CALL us @ 313-866-5333**

Safe:	State-licensed pharmacy
Affordable:	\$8.30 per RX
Convenient:	In most cases, your medicine can be mailed directly to your home, or you may pick it up from our agency.

**You may qualify if you:**



- Are 18 years of age or older, and live in Michigan
- Earn \$36,200 or less per year if you are single; \$41,400 for a couple.
- Do not have prescription drug coverage, or are under insured.
- Are not currently enrolled in Medicaid, or if so, may need a medication not covered by Medicaid.

***You may still qualify if you are a senior on Medicare Part D.***



**Have you lost your insurance coverage?  
Have you been impacted in any way by the COVID19 virus?  
Do you know someone who has?  
We would be glad to talk to you or them about our program!**

**PLEASE CALL FOR MORE INFORMATION OR FOR AN APPLICATION FORM**

**WORLD MEDICAL RELIEF, INC.**  
21725 Melrose Ave., Southfield, MI 48075, Phone: 313-866-5333, Fax: 313-866-5588  
email: [info@worldmedicalrelief.org](mailto:info@worldmedicalrelief.org), website: [www.worldmedicalrelief.org](http://www.worldmedicalrelief.org)

**OTHER AVAILABLE ITEMS through World Medical Relief include:**

**Durable Medical Equipment** such as a hospital bed, wheelchair, shower chair, walker, cane, commode, etc., **AND** **basic medical, and colostomy supplies, liquid nutrition, incontinent products and our diabetes program.**