DSS-AA-677 01/09

PATIENT ASSISTANCE PROGRAM

Date: _____

Name: _____
First MI Last

Address: _____

City/State/Zip: _____

Email Address:_____

Telephone Number: _____

Date of Birth: _____

Soc. Sec. # _____

Physician: _____
First MI Last

Clinic: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Do you receive Medicare Part A, B, or D benefits?
Yes ____ No ____

Sex: _____

Married ___ Single _____ Widowed ____

- **I authorize any health professional to release to the Patient Assistance program, any information with respect to myself that may be related to the Application Assistance application, including any relevant review of drug therapy. I declare and affirm under the penalties of perjury, that this information has been examined by me and to the best of my knowledge and belief, is in all things true and correct.**

Client's Signature _____ Date: _____

Eligibility and application requirements vary by drug company. An applicant typically has to apply to each program separately. If you have access to a computer, at home or at a local library, log on to www.needymeds.com or www.pparx.org for prescription assistance. If you do not have access to a computer, mail this completed form and 6 month pharmacy printout to:

Adult Services & Aging, 700 Governors Drive, Pierre SD 57501-2291
Toll Free Number - 1-866-854-5465

Note: The Patient Assistance Program is intended to be a temporary solution to ease the financial burden of purchasing medications. The program does not guarantee that all of your medications will be covered or that you will be eligible within each program.

If you are assisting with the completion of this form and applications; please list your name, address and telephone number below.

Name: _____ Phone Number: _____

Address: _____

List below all medication, dosage, form, how often and why you are taking.

Drug	Mg.	Frequency	Form	Why are you taking?	How long have you taken?
Example Pepcid	20 mg.	1 a day	Tab	Ulcers	2 years