Bland County Medical Clinic

☐ DENIED ACCEPTED☐

☐ Signatures
☐ Patient Copies
☐ Proof of Income

Medical Assistance Program (MAP) - Application

Welcome to the Medical Assistance Program (MAP). Bland County Medical Clinic is dedicated to giving the best medical attention possible to our patients. MAP is here to assist you in receiving your medications at a reasonable price. MAP offers chronic medicine to those with or without prescription coverage who cannot afford to purchase their medication.

Please be sure to fill out the application *completely* and initial and sign *all* areas on the patient contract and forms or they will not be processed by MAP.

Medications available through MAP:

- Diabetes
- High Blood Pressure
- Cholesterol
- Antidepressants

Proof of income is required for this program. You will need a 1040 Tax Form, pages 1 and 2 and/or Social Security Award letters. These are the only proof of income the manufacturers will accept.

The medication will be requested from a pharmaceutical company and must only be delivered to Bland County Medical Clinic. If your medication is delivered to your home and you do NOT notify BCMC, you will not receive any refills. Medications will not be mailed from BCMC to your home under any circumstances.

If you are unable to have the medication picked up within two (2) weeks from the time we notify you, your medication will be dispersed to other patients in the MAP program. The Clinic will NOT order any other medication for you. If you cannot pick up your medication, please contact MAP.

If your dosage has changed and your prescribing practitioner is at a different facility, it is your responsibility to let MAP know.

If you have any questions, please contact Bland County Medical Clinic.

12301 Grapefield Road, Bastian, Virginia 24314 | PH: 276-688-4331 ▪ FX: 276-688-4336

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Medical Assistance Program (MAP) - Contract

INSTRUCTIONS: Please read and initial this contract carefully. Make sure you understand each of the paragraphs. This contract will be null and void without your signature when complete. If you are not sure of these statements, please feel free to ask for help.

This contract will be on file at Bland County Medical Clinic. A copy will be given to you to keep in your personal records. DO NOT THROW THIS CONTRACT AWAY. By signing this contract, you agree to abide by the responsibilities and conditions of this program.

_____ I agree to provide Proof of Income that is legitimate and current upon request and update documentation annually, or as needed, by the representative of the Medicine Program. I authorize any agent of the program to verify the information I provide. This may be done through my bank, Social Security Administration, Veterans Administration, my employer, or any other source from which I receive income. I understand that not providing requested documentation would result in being removed from the program.

_____ I understand that this is not a reimbursement program and that I am solely responsible for any medications I have previously purchased and may need to purchase in the future.

_____ I agree to follow the Chronic Care Protocols established by Bland County Medical Clinic (including appropriate labs, EKG, and X-Ray) and have a physical exam by a Provider at the Clinic every three (3) to six (6) months depending on my age and medical condition(s). Failure to show up for or to keep timely appointments will prohibit medication being ordered and/or dispensed.

DIABETICS – EVERY THREE (3) MONTHS NON –DIABETICS – EVERY SIX (6) MONTHS

_____ I understand that there may be delays in getting my medicine and that should I run out of my medicine before it is delivered, I am solely responsible for obtaining my medications until they arrive. Additionally, should there be any medications that are unavailable through the program; I understand it is my responsibility to obtain those without reimbursement from the program.

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_____ I agree to promptly notify the patient advocate upon any changes in my income or the income of any of those in the household, number of people in the household, address, or phone.

_____ I understand that inappropriate behavior on Bland County Medical Clinic property and/or such behaviors directed to any staff member of the Clinic or this program will result in immediate and permanent dismissal from this program. This includes foul language, threats of any kind, verbal abuse, and unsuitable conduct verbal or otherwise. We will not tolerate being treated with disrespect.

_____ Medications not picked up will be given out as samples and you will be removed from the program. If medication is delivered to my home, I agree to let the Patient Advocate know as I receive it; I understand that failure to do so will result in being removed from the program.

_____ I authorize any agent of the program to review my medical chart as necessary to be able to order correct medications. I also authorize the representative(s) to discuss my medical condition(s) and needs with my Provider to ensure correct medications are ordered.

_____ My signature below authorizes the Patient Advocate of the program to sign my name on the necessary forms needed to order my medication. The purpose of this is to expedite the ordering process by eliminating the mailing of forms back and forth for signature.

_____ It is my responsibility to contact the Patient Advocate when there is a change in medication including dosage change or no longer taking or added.

_____ I understand that neither this program nor their agents are in any way guaranteeing or promising medication to me.

I have read (or have had them read to me) and understand the Medication Assistance Program (MAP) guidelines and agree to follow all of the above requirements for the duration of any assistance I receive from MAP.

PATIENT SIGNATURE	PATIENT PRINTED NAME
DATE	PATIENT ADVOCATE SIGNATURE

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Medical Assistance Program (MAP) – Patient Info

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

County: _____ Contact Number: _____

Gender (circle): MALE FEMALE Birthdate: ____/____/____

Marital Status (circle): MARRIED SINGLE DIVORCED WIDOWED LEGALLY SEPERATED

SSI Number: _____-____-_____ Total in household (including yourself): _____

(OPTIONAL) Race (Circle): WHITE ASIAN BLACK/AFRICAN AM NATIVE HAWAIIAN

PACIFIC ISLANDER AMERICAN INDIAN/NATIVE ALASKAN

THE FOLLOWING PEOPLE ARE AUTHORIZED TO PICK UP MY MEDICATION:

Name: _____

Relation to you: _____

Name: _____

Relation to you: _____

Name: _____

Relation to you: _____

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YOUR HEALTHCARE PROVIDER (circle one – THIS IS REQUIRED)

Dr. Michael Crews, DO	Dr. John Turski, DO	Debbie Croy, DNP, ANP
Ellen Lambert, FNP	Mary Jo Collie, DNP, FNP	Elaine Harper, ANP
Carolyn King, FNP	Angela Hutchinson, FNP	Anna Pettrey, FNP-BC
Lindsey Kennedy, FNP	Sharon Cecil, FNP	Deanna Michelle McCarty, FNP

DO YOU HAVE RX COVERAGE OF ANY KIND? ☐ YES ☐ NO

IF YES, MAP NEEDS A COPY OF YOUR CARD.

INSURANCE COVERAGE (You must circle one)

Medicare (A&B)	Medicare Supplement	Employer Provided
Medicare Advantage Plan	Medicare (Part D)	Medicaid
Veteran Benefits		None – Uninsured

Other (please specify): _____

INCOME

☐ 1040 Tax Form, Page 1 and 2 ☐ Social Security Award Letter

Additional Household Income:

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Medical Assistance Program (MAP) – Signature

I certify by my signature below, that the information I have provided is true and correct and that the agent of the Medication Assistance Program (MAP) can verify the above information using the necessary means.

PATIENT SIGNATURE

PRINTED PATIENT NAME

DATE

PATIENT ADVOCATE SIGNATURE

DATE

NOTES

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