CLIENT PRE-QUALIFYING APPLICATION
AFFORDABLE PRESCRIPTION PROGRAM

WORLD MEDICAL RELIEF, INC.

11745 Rosa Parks Blvd., Detroit, MI 48206, 313-866-5333, fax: 313-866-5588

Name:_____ Address:_____

City:_____ State: _____ Zip: _____ County: _____ Phone ( ) _____

SSN: _____ - ___ - _____ DOB:____ / ___ / ____ Marital Status: S___ M___ W ___ D ___ Sep__

US Citizen: Yes___ No___ Male: ___ Female: ___ Disabled: Yes___ No___

Caucasian__ African American__ Hispanic__ Arabic/Chaldean__ Asian__ Native American__ Other__

Employment Status: Retired __ Unemployed __ Full time __ Part-time __

Emergency contact person_____ Contact phone #:_____

List All Your Prescriptions

MEDICATION NAME	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 Salary Wages:	$	Unemployment:	$	Alimony:	$
SS Retirement:	$	Pension/Retirement:	$	Other:	$
SS Disability:	$	Interest/Annuity/IRA:	$	Total Income:	$

For this application to be approved, you must include documentation of your monthly household income: pay stub, unemployment info, pension information etc. along with a bank statement. Return all in enclosed envelope.

The above information is correct to the best of my knowledge_____

Signature and date

Please use back of application to tell us how you heard about our prescription program. Thank you. 7/11

Please tell us how you heard about our prescription program.

_____

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Agency Site Worker – please be sure to fill in the information below. Thank you

Agency name_____

Site Worker's name_____

Phone Number_____