



Prescription Assistance

Application

Union County Senior Services' Prescription Assistance Program was established to help meet the rising demands of prescription drug costs for Union County Seniors age 60 and over who do not qualify for Medicaid or Medicare Extra Help, but who are unable to afford the prescription drugs they need. **In addition to this program, Union County Senior Services will work with seniors to explore a variety of other programs that are available to help them with their prescription drug costs.**

Assistance is awarded based on need, eligibility and availability of funds. **Please be sure to fill in all of the blanks and attach all appropriate documentation.**

This program is funded through the Union County Senior Services Sales Tax.

Date		Phone Number(s)	
Name		Date of Birth	
Address			
Marital Status	Gender	Ethnicity	Number in Household

Description of Need

Please provide a brief description of your current situation and why you are in need of financial assistance for your prescription drug costs:

Over for Financial Eligibility Form on back to determine Cost-Share



Union County Senior Services

18000 SR 4, Suite D128

Marysville, OH 43040

phone: 937.644.9629

www.ucseniors.org

Funded by the Senior Services Sales Tax Administered by Union County Senior Services

Financial Eligibility Form

Date _____

Monthly Income - verify by checking all items that apply

Social Security	_____	\$ _____
Pension	_____	\$ _____
Interest Income	_____	\$ _____
Other Income		
(RR, VA, Dividends,	_____	\$ _____
Rental Income	_____	\$ _____
Spouse's Income	_____	\$ _____
Total Income		\$ _____

Household Assets - verify by checking all items that apply

Savings Account	_____	\$ _____
Checking Account	_____	\$ _____
CDs, Money Mkts,		
IRAs, Stocks, etc.	_____	\$ _____
Total Assets		\$ _____

Signature

I hereby declare I am a Union County resident age 60 or older, have a gross income not exceeding \$1,815 / month if single or \$2,452 / month household of two; and with assets of no more than \$1,500; and am not eligible for Medicaid or Medicare Extra Help. **I understand that a credit will be applied to an account in my name at Dave's Pharmacy in Marysville, Ohio to be used only for necessary prescription drugs as prescribed for me by my doctor.** I also certify that the information I have provided in this application is, to the best of my knowledge, a true, accurate and complete disclosure of the requested information. I understand that I may be held civilly and criminally liable under Federal and State Law for knowingly making false or fraudulent statements.

Applicant's Signature: _____

Date: _____

Attach Documentation

Attach proof of income as well as a copy of the costs of your current medications or your latest statement from your insurance provider.