



Dear *NC MedAssist* Applicant,

The North Carolina Association of Free Clinics (NCAFC) and NC MedAssist of Mecklenburg Pharmacy look forward to serving your prescription medication needs through a pilot project funded by the NC Attorney General, called *NC MedAssist*. The NC MedAssist program is in place to assist uninsured and low-income North Carolinian's gain access to prescription medications with the benefit of having your prescription medications mailed to your home.

The NC MedAssist program does require you to meet eligibility criteria. The attached application and all required documents must be submitted for determination of eligibility and approval into the program. Once approval or denial has been determined, you will be notified.

**Enrollment into the NC MedAssist program can be completed with three options:**

Option 1: Locate and Visit a NC Enrollment Site in your county.

Option 2: Go online, Download, Print and Complete the NC MedAssist Enrollment Application.

Option 3: Call NC MedAssist and request the NC MedAssist Enrollment Application be mailed to your home.

**Who is eligible to enroll in the program?**

North Carolina residents who are:

1. Adults and children living at or below 200% of the Federal Poverty Level.
2. Adults and children who **do not qualify** for: Medicaid, Veterans Administration or private health insurance.
3. Medicare Part D participants who fall in the "donut hole" **may** be eligible after consultation with NC MedAssist.

**Supporting Documents for the Application and Proof of NC Residency:**

1. Medical History, Allergies and a list of prescribed medications
2. Contact information for your personal physician
3. Prescription Drug Benefits (if applicable)
4. Documents supporting proof of income - the following will be accepted:
  - a. 1040 Tax Return(s) for current year
  - b. 1099 Benefits Statement(s) for current year
  - c. 4506 – T Form(s) (if applicable)
  - d. Pay Stubs from employer
5. Documents supporting proof of NC residency - Phone Bill, Lease Agreement or Utility Bill.

\* Note: NC MedAssist may only fill prescription medications from a list of Drugs that are available to them. The MedAssist Drug List does not include controlled drugs/narcotics.

**Caring for North Carolina,  
The NC MedAssist Team**



## WHAT IS NC MedAssist?

NC MedAssist is a statewide prescription assistance program created to assist uninsured and low-income North Carolinian's gain access to prescription medications; eligible applicants have the opportunity to obtain donated FREE brand name and generic prescription medications necessary to help maintain a healthy lifestyle.

## WHO IS ELIGIBLE?

### Who is eligible to enroll in the program?

North Carolina residents who are:

1. Adults and children living at or below 200% of the Federal Poverty Level.
2. Adults and children who **do not qualify** for: Medicaid, Veterans Administration or private health insurance.
3. Medicare Part D participants who fall in the "donut hole" **may** be eligible after consultation with NC MedAssist.

## WHAT FORMS OF ID ARE NEEDED TO PROVE NC RESIDENCY?

The following documents will be accepted to prove NC Residency: **Phone Bill, Lease Agreement or Utility Bill.**

## HOW MUCH DO I HAVE TO PAY TO ENROLL?

Currently, you are not required to pay an enrollment fee; however, for future sustainability an annual enrollment fee may be administered.

## HOW DO I ENROLL?

### OPTION 1:



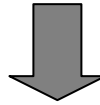
**Locate** the NC MedAssist Enrollment Site in your county and schedule an appointment to fill out the enrollment application.

Find an Enrollment Site in your county by:  
Going Online to NCAFC at [www.ncfreeclinics.org](http://www.ncfreeclinics.org)

OR

Calling NC MedAssist at 1-866-331-1348

OR



**MOVE TO OPTION 2 IF THERE IS NOT AN ENROLLMENT SITE IN YOUR COUNTY.**

**OPTION 2:**

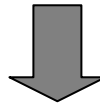
Download and print the *NC MedAssist Enrollment Application* from:



NC MedAssist at [www.medassist.org](http://www.medassist.org)

OR

NCAFC at [www.ncfreeclinics.org](http://www.ncfreeclinics.org)



**Complete and Mail** the application with supporting documents to:  
**NC MedAssist, 5516 Central Avenue Charlotte, NC 28212.**



**MOVE TO OPTION 3 IF YOU DO NOT HAVE ACCESS TO THE INTERNET.**

**OPTION 3:**

Call NC MedAssist at 1-866-331-1348 and request an *NC MedAssist Enrollment Application* be mailed directly to your home.



## WHAT SUPPORTING DOCUMENTS DO I NEED FOR THE APPLICATION?

You should be prepared to provide the following information to complete the enrollment application:

1. Medical History, Allergies and a list of prescribed medications
2. Contact information for your personal physician
3. Prescription Drug Benefits (if applicable)
4. Documents supporting proof of income - the following will be accepted:
  - 1040 Tax Return(s) for current year
  - 1099 Benefits Statement(s) for current year
  - 4506 – T Form(s) (if applicable)
  - Pay Stubs from employer

## WHEN WILL I RECEIVE MY PRESCRIPTION MEDICATION?

After your enrollment application is received and processed by NC MedAssist; please allow 7-10 business days to receive your prescription medication.

**For more information, please contact:**

North Carolina Association of Free Clinics

P.O. Box 25893

Winston-Salem, NC 27114

Phone: 336-251-1111

Fax: 336-251-1110

Website: [www.ncfreeclinics.org](http://www.ncfreeclinics.org)

NC MedAssist

5516 Central Avenue Charlotte, NC 28212

Phone: 1-866-331-1348

Fax: 704-536-9865

Website: [www.medassist.org](http://www.medassist.org)





## ENROLLMENT APPLICATION

**Phone:** (704) 536-1790

**Fax:** (704) 536-9865

**Address:** 5516 Central Avenue, Charlotte, NC 28212

<p><b>Applicant's Name</b></p> <p>_____</p> <p style="text-align: center;"><i>(first) (middle initial) (last)</i></p> <p><b>Address</b> _____</p> <p>_____</p> <p style="text-align: center;"><i>(city) (state) (zip)</i></p> <p><b>County of Residence</b> _____</p> <p><b>Social Security #</b> _____</p> <p><b>Phone Contact</b> (____) _____</p> <p><b>Alternate #</b> (____) _____</p> <p><b>Emergency Contact:</b> _____</p> <p style="text-align: center;"><i>(name other than applicant)</i></p> <p><b>Emergency Contact Phone#</b> (____) _____</p>	<p><b>DOB</b></p> <p>_____</p> <p><b>Gender</b></p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><b>Height</b> _____</p> <p><b>Weight</b> _____</p> <p><b>Marital Status</b></p> <p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>	<p><b>For office Use Only</b></p> <p>Date Entered _____</p> <p>Applicant # _____</p> <p>Recert Date _____</p> <p>Approval Notification Date: _____</p> <p>Applicant _____</p> <p>POE _____</p> <p><b>Ethnicity</b></p> <p><input type="checkbox"/> Caucasian <input type="checkbox"/> African American</p> <p><input type="checkbox"/> Hispanic <input type="checkbox"/> Asian</p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Other _____</p> <p><b>Primary Language Spoken:</b> <i>(other than English)</i></p> <p>_____</p>
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<b>Medical History</b>	<b>Allergies</b>	<b>Medications</b>
<p>List any drug, food or other substance allergies:</p> <p>_____</p>	<p>List all prescription medications, over the counter medications, vitamins, supplements or herbs you are currently taking: ( <input type="checkbox"/> √ if attaching a List )</p> <p>_____</p>	<p>_____</p>

<p><b>Illnesses</b></p> <p><i>Circle any that you may have</i></p>	<p>Acid Reflux/Ulcers    Arthritis    Asthma    Anxiety    COPD    Chronic Bronchitis    Congestive Heart Failure</p> <p>Depression    Diabetes    Emphysema    High Blood Pressure    High Cholesterol    Seizures    Thyroid Problems</p> <p>List any others: _____</p>
<p>How many <b>Hospital Admissions</b> have you had in the past year? _____</p> <p>How many times have you been to an <b>Emergency Room</b> in the past year? _____</p>	

<b>Physician Information</b>	
Applicant's Physician:	_____
	<i>(Prescribing Physician's Name)</i>
Physician's Address:	_____
	_____
Phone #	(____) _____



**Prescription Drug Benefits**

*Check any that apply to your current benefit status*

- NO Insurance/NO Prescription Drug Coverage
- Medicare Part D Coverage
- Medicare Part D Coverage presently in "GAP – Donut Hole" status
- Medicaid
- Veterans Administration (VA)
- Private Insurance Coverage : \_\_\_\_\_

(Carrier)

**House Hold Income**

*Documents supporting Proof of Income are Required with submission of this Application*

How many people live in your household, including you? \_\_\_\_\_ Adults \_\_\_\_\_ Children (<18 yrs old)

What is the TOTAL gross income of the entire household?

\$ \_\_\_\_\_ /month

\$ \_\_\_\_\_ /yr

Are you employed? Y / N (circle), if so where \_\_\_\_\_

Have you been laid off from employment in the past year? Y / N (circle)

What is the source(s) of your Household Income? (Wages, Unemployment, Social Security, SSI, Disability, etc)?

✓ *Required Document(s) that you are submitting with this application as proof of income for each adult member of the household*

- 1040 Tax Return(s) for current year
- 1099 Benefits Statement(s) for current year
- 4506 – T Form(s) only if you did not file a federal tax form  
Pay Stubs from employer

*See Letter of Introduction describing submission of Supporting Documents*

**Applicant's Agreement/Disclosure/Release**

I attest that the information I have given in this enrollment application (pages 1 & 2) is accurate and true, I also understand that even if my application is approved, services are not guaranteed. By signing this application I release NC MedAssist, its affiliated drug companies and any public or private agencies or financial supporters and their agents from any and all claims of liability in contract or tort arising out of the actions of NC MedAssist, its agents, employees, or P.O.E in performing services or related to services I receive from NC MedAssist. I give my consent to DSS and DHHS to advise NC MedAssist of the status of a pending Medicaid application. I will notify NC MedAssist if I become eligible for Medicare, Medicaid, private insurance or VA benefits, or if my income changes within 30 days. I also give consent to NC MedAssist to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state and local laws and regulations and purposes directly related to the administration of NC MedAssist programs and grants. I have received NC MedAssist's Notice of Privacy Practices Statement and authorize NC MedAssist to ship my medications to:

**Sponsoring Point of Entry Name, City & Phone #**

Will someone other than you (*applicant*) be picking up your medications from the Point of Entry site? Y / N (*circle*)

If so, list who & relationship \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

(✓) If Pre-Enrollment previously submitted to NC MedAssist

*Currently participating patients in the pilot program are not required to pay an enrollment fee; however an annual enrollment fee may be administered in the future.*



## Who is eligible?

North Carolina residents who are:



**Adults and children living at or below 200% of the Federal Poverty Level.**

### 2010 GUIDELINES FOR 200% OF THE FEDERAL POVERTY LEVEL

# of People Living in Your House	Annual Income	Monthly Income
1	\$ 21,660/yr or less	\$ 1,805.00 or less
2	\$ 29,140/yr or less	\$ 2,428.33 or less
3	\$ 36,620/yr or less	\$ 3,051.67 or less
4	\$ 44,100/yr or less	\$ 3,675.00 or less
5	\$ 51,580/yr or less	\$ 4,298.33 or less
6	\$ 59,060/yr or less	\$ 4,921.67 or less
7	\$ 66,540/yr or less	\$ 5,545.00 or less
8	\$ 74,020/yr or less	\$ 6,168.33 or less
*For family units of more than 8 members, add \$ 3,740 to Annual Income		



**Adults and children who do not qualify for: Medicaid, Veterans Administration or private health insurance.**



**Medicare Part D participants who fall in the “donut hole” may be eligible after consultation with NC MedAssist.**

**For more information to enroll please call**

**NC MedAssist at 1-866-331-1348**

**Or visit**

**[www.medassist.org](http://www.medassist.org)**