

Portsmouth Area Short-Term Medical Assistance Application

Name:		Phone:		
Street Address:		Mail Address:		
City:		DOB:	Age:	Family Size:
State:	Zip:	Social Security # _____ - _____ - _____		

Marital Status

Married
 Single
 Divorced
 Widowed
 Legally Separated

Race Please check all appropriate spaces. (Optional)

White
 African American
 Asian
 Hispanic
 American Indian

Other Household Members

Name	DOB	Relationship	Household Member Gross Income

Total Other Household Member Income _____

Applicant Gross Income

	Weekly	Monthly	Yearly		Weekly	Monthly	Yearly
Gross Wages:				Welfare Payments:			
SSI:				Child Support:			
Retirement Income:				Alimony:			
Business Income:				SSD:			
Unemployment:				Other:			

Total All Income:

Employer: _____ **Address:** _____

Phone: _____

Insurance Information

Do you have health insurance ? Yes No Does it cover prescriptions? Yes No

Insurance Provider: _____

Do you have Medicare? Yes No Are you a veteran? Yes No

Have you applied for Medicaid? Yes No Date of application _____

Primary Physician: _____

Physician Address: _____

I certify that all the information is true, and I hereby authorize Community Services to verify any of this information with my employer, agencies and/or my mutual providers and release/share information necessary to provide this service. I agree to contact Community Services in the event that any of the above information changes. If it is found that information is inaccurate, Community Services reserves the right to discontinue services. Community Services **reserves the right to have our Medical Director monitor certain classes of medication.**

The Medical Financial Assistance Program has an expenditure limit of \$200 while funds are available. It has been explained to me that any charges beyond this amount will be my responsibility and will be paid directly to the service provider.

_____ Date _____
Applicant Signature

This section is to be filled out by Support Coordinator or authorized agent.

Proof of Residence Shown:

___ Drivers License ___ Lease/Mortgage Info ___ Utility Bill ___ Bank Statement ___ Other

Proof of Income Shown:

___ 2 Current consecutive pay stubs ___ Unemployment check stub ___ IRS tax return
___ Bank statement ___ Employer income statement ___ Other(describe)_____

I verify this person appeared before me and produced the above indicated information

_____ Date _____
Authorized Signature

**Community Services
Portsmouth Area Medication Assistance Program
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Portsmouth, NH 03801
Tel: (603) 422-8220 Fax: (603)422-8220**