

PERSONAL INFORMATION

Name: _____ Date: _____

Address: _____ Cell Phone: _____

County: _____ Birth Date: _____

Marital Status: _____ Race: _____ Social Security No.: _____

Own or Rent: _____ Veteran? Yes No

Number of people living in household: _____ Spouse's Name: _____

How did you hear about MediAppS? _____ Email: _____

Physician Name: _____

Clinic: _____ Pharmacy: _____

Primary Health Insurance: _____

Supplemental Insurance: _____

Prescription Drug Coverage: _____

Medication Allergies: _____

List the Medications and/or Equipment you are seeking help with:

_____	mg/mcg: _____	Diagnosis: _____
_____	mg/mcg: _____	Diagnosis: _____
_____	mg/mcg: _____	Diagnosis: _____
_____	mg/mcg: _____	Diagnosis: _____
_____	mg/mcg: _____	Diagnosis: _____
_____	mg/mcg: _____	Diagnosis: _____

Proofs Required:	Federal Income Tax Return (1040)	One month's worth of pay stubs
	Social Security/Disability Benefit Letter	Unemployment Statement
	Photo ID	Child Support Award Letter

Medication Application Service (MediAppS)

FINANCIAL INFORMATION

Do you file taxes Yes No

MONTHLY INCOME	Amount
Wages (gross/before taxes)	\$ _____
Wages after taxes - spouse/partner	\$ _____
Social Security or SSI Income	\$ _____
Social Security or SSI Income - spouse/partner	\$ _____
Pension	\$ _____
Unemployment Compensation	\$ _____
Cash Assistance	\$ _____
Food Support	\$ _____
Total Monthly Income	\$ _____

MONTHLY EXPENSES	Amount
Rent/Mortgage Payment	\$ _____
Utilities - Electric and Gas	\$ _____
Water/Sewer	\$ _____
Garbage	\$ _____
Phone(s)	\$ _____
Cable/Satellite/Internet	\$ _____
Car Loans	\$ _____
Car Insurance	\$ _____
House Insurance	\$ _____
Insurance - Other	\$ _____
Property Taxes	\$ _____
Transportation (gas, bus, ride share, etc.)	\$ _____
Groceries - not including Food Support	\$ _____
Fast Food/Restaurants/Snacks	\$ _____
Baby Needs (diapers, formula, etc.) - minus WIC	\$ _____
Daycare	\$ _____
Child Support/Alimony	\$ _____
Clothing	\$ _____
Medicine and/or Medical Bills	\$ _____
Personal & Household (hygiene and cleaning)	\$ _____
Laundry	\$ _____
Haircuts, Manicures	\$ _____
Alcohol, Cigarettes, Vaping Supplies, etc.	\$ _____
Pet Food and Supplies	\$ _____
Subscriptions (Netflix, Hulu, Spotify, etc.)	\$ _____
Credit Cards	\$ _____
School Loans	\$ _____
Total Monthly Expenses	\$ _____

I certify that the information on this application is true and correct.

Date _____
Signature _____

RELEASE OF INFORMATION

I, _____ ,
(print) First MI Last Name Date of Birth

Hereby give permission to Sheila Filla and/or Catholic Charities of Southern Minnesota to release information regarding my medication and financial information to/from doctors/nurses, clinics, pharmacies, medical supply stores, public health/county employees, local non-profit service agencies, and insurance/drug companies. This information will be regarded as confidential and maintained in the Catholic Charities MediAppS client file.

This information will be used to apply for patient assistance programs, to secure medications from pharmacies, and to verify eligibility for other county/local assistance programs.

I understand that this permission expires in two years from the date signed. I also understand that I may revoke this consent at any time prior to two years.

Signature

Date

Minor Child's Name: _____

Minor Child's Date of Birth: _____

**STATEMENT OF CLIENTS RIGHTS
AND RESPONSIBILITIES**

MediAppS Program Goals:

- Help clients secure, on a short-term/temporary basis, prescription medications, and medical devices because they cannot afford them.
- Help clients develop and implement long-term strategies for meeting their prescription needs. This may include initiating enrollment and ongoing participation in various government or private programs.
- Manage resources so that the most persons may benefit.
- Serve clients in accordance with the Mission and Values of Catholic Charities of Southern Minnesota.

Client Rights:

- To receive services regardless of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, mental/physical handicap, or any other reference or personal characteristic, condition or status.
- To be treated with respect in a manner that upholds human dignity.
- To have your information handled confidentially and released to other parties only with your consent.

Client Responsibilities:

- To treat MediAppS and Catholic Charities staff with respect in a manner that upholds human dignity.
- To always respond honestly and truthfully.
- To provide authentic documentation in a timely manner to all parties assisting with your medical needs.
- To promptly take the steps necessary to receive assistance and to enroll in and maintain enrollment in the government or private programs.
- To respect Catholic Charities' commitment to providing only services that aligns with its ethical standards, which include the teachings of the Catholic Church.

Acknowledgment and Agreement:

By signing this document, I fully acknowledge and understand my rights and responsibilities as a MediAppS client. I agree to act in accordance with the MediAppS Program to the best of my ability. I further acknowledge and agree that Catholic Charities may terminate my services if I fail to act in accordance with my responsibilities. I may request a copy of this document.

Name (Print)

Signature

Date

Catholic Charities of Southern Minnesota

111 Market Street * P.O. Box 379 * Winona, MN 55987 * (507) 454-2270 * fax (507) 457-3027