Cajun Area Agency on Aging
P.O. Box 60850
Lafayette, LA 70596
(800) 738-2256

Please complete and return to your Area Agency on Aging.

CLIENT APPLICATION

Social Security Number: _____ Medicare Number: _____ Parish: _____
Last Name: _____ First Name: _____ MI: _____
Mailing Address: _____ Race/Ethnicity: White ___ African American ___ Other ___
Street Address: _____ Birthdate: ____/____/_____ Gender: ____Male ____Female
City/Zip: _____ Home Phone: _____

Medicare Enrollment Dates Part A _____ Part B _____ Part D _____

Did you file income taxes last year? ____Yes ____No

Employment Status: ____Retired ___Disabled
____Full time ___Part time

Marital Status: ___Married ___Single ___Widowed Spouse's Name: _____

Are you a legal U.S. resident? ____ Yes ____No

Are you a veteran or veteran's spouse/widow? __Yes __No

Spouse's Social Security Number: _____
Number living in household (including client): _____

Primary Physician: _____
Name Address Phone

Emergency Contact: _____
Name Phone Relationship

SOURCES OF INCOME

(We MUST HAVE a copy of proofs of income for EVERYONE who lives in your household)

TOTAL MONTHLY INCOME $ _____ TOTAL ANNUAL INCOME $_____

Salary/Wages $ _____ Unemployment $ _____ Social Security Disability $ _____
Veteran's Benefits $ _____ Child Support $ _____ Social Security $ _____
Workman's Comp $ _____ Pension $ _____ SSI $ _____
Railroad Retirement $ _____ Interest Income $ _____ Other $ _____

(Attach Copies of W@ forms, Tax returns, bank statements, social security benefit statements and any other sources of income).

Are you currently enrolled in any prescription assistance or discount programs? _____ Yes _____No

Are you enrolled in _____ Medicare _____ VA Benefits _____SLMB _____ QMB # _____

Do you have insurance covering prescription drugs? _____
(Other than Medicare/Medicaid) Company Policy #
Do you have Medicare Supplemental Policy? _____
Company Policy #

***If you have more than one prescribing physician, please attach a list with each doctor's name, address and telephone number. Louisiana SenioRx cannot guarantee that you will receive all of the medicines requested.**

Medication	Directions/Strength	Prescribing Doctor and Phone	Manufacturer and Cost
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			

Medical Conditions: (please circle) Heart Asthma High BP Ulcer Glaucoma
Other: _____

Medical Allergies: (please circle) None Sulphur Penicillin
Aspirin Codeine Iodine
Other:_____

Louisiana SenioRx
Linking Seniors to Pharmaceutical Aid

PATIENT CONSENT AND RELEASE FORM
EXCHANGE OF INFORMATION

I give permission to authorized representatives of the Louisiana **SenioRx** to inspect my medical records whenever necessary to obtain pertinent information needed to solicit medications on my behalf from companies that manufacture or provide medications through patient assistance programs. I also authorize **SenioRx** to discuss my medical needs and me with my physician when necessary. Additionally, I give **SenioRx** permission to verify my income through the Social Security Administration, my employer, Veterans Administration or any other company, business or organization from which I receive income. This authorization is good as long as **SenioRx** is assisting me or until I revoke such.

I want a copy of this form to be accepted as a valid consent to share information.

If I do not sign this form, information will not be shared, and I will have to contact each agency, company, or organization individually to give them information about me that they need.

DOB: _____ SSN: _____

ADDRESS:_____

FULL PRINTED NAME OFPATIENT:_____

SIGNATURE:_____DATE:_____

PATIENT SIGNATURE AUTHORIZATION

I authorize representatives of Louisiana **SenioRx** to sign forms on my behalf for the purpose of soliciting medications on my behalf from companies that manufacture or provide medications through patient assistance programs. This signature authorization is good as long as **SenioRx** is assisting me or until I revoke such.

FULL PRINTED NAME OF PATIENT: _____

SIGNATURE: _____DATE: _____

Please complete and return with application to:
Louisiana SenioRx
c/o

CLIENT CHECKLIST

This application packet should be mailed back to your SenioRx Program (listed at the top) with ALL the requested information. **Please verify that you have attached each item by filling out the check list, then sign and return with your application.**

____ **Completed application**

____ **Completed and signed "Patient Consent and Release Form"**

____ **Attach proof of income for each member of household (current tax form, Social Security Benefit letter or current bank statement)**

____ **List or attach all medications with strength and diagnosis and how often taking, and all physician information required on application**

____ **Proof of all insurance (copy of all cards), Medicaid and Medicare cards as well**

I understand that failure to include all requested information will delay completion of my application.

Signature: _____ Date: _____