

ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH
PRESCRIPTION DISCOUNT PROGRAM

This is an application for the Anne Arundel County Department of Health **Prescription Discount Program**. The **Prescription Discount Program** offers Anne Arundel County residents access to reduced rates on prescription medications.

In order to apply you must:

1. Complete, sign and date the application

2. Not have pharmacy coverage through any insurance, or be eligible for any governmental pharmacy benefits program (Medical Assistance) or have a Maryland Pharmacy Assistance card

3. Provide proof of all income

For example, provide a copy of one (1) of the following:

- Pay stub (must be consecutive payment periods, for a period of four weeks)
- Wage statement from employer or social security award letter (same as above)
- Last years Federal Income Tax (W-2) Return

4. Provide proof you live in Anne Arundel County

Provide a copy of one of the following:

- Driver's License or other identification card with name and address
- Lease/mortgage/utility bill with name and address

If you have any questions, feel free to contact the **Prescription Discount Program** at **(410) 222-4548**.

ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH
PRESCRIPTION DISCOUNT PROGRAM
APPLICATION (PLEASE PRINT)

HEAD OF HOUSEHOLD

Last Name _____ First Name _____ M.I. _____

Residence Address _____ Apt. or Floor # _____

City _____ State _____ Zip Code _____

Home Phone # (_____) _____ Work Phone # (_____) _____

Mailing Address (if different from above) _____

City _____ State _____ Zip Code _____

Household Please list everyone in your household (including yourself)

Are you applying for this person?		Name	Relationship to you	Date of Birth	Race	Sex
Y	N		SELF			
Y	N					
Y	N					
Y	N					
Y	N					

Income Information List income from all sources, including wages, earning, or money from a job or self-employment, alimony, child support, pension, social security, rental income, retirement, strike benefits, unemployment, veterans, workers compensation benefits that you, your spouse or others listed in your household may receive. **(attach copy of income statements)**

Name of Employed Person	Name of Employer Or Type of Benefit	Address of Employer	Work Telephone#	Gross Amount	Frequency (wkly/biweekly)

Do you or anyone applying for the Prescription Discount Program have any insurance coverage for prescription medicines? Yes No

Where did you hear about Prescription Discount Program? Mail Health Department Friend Doctor Advertisement Department of Social Services Department of Aging School Other

If more room is needed for details, attach a sheet of paper to the application.

CONFIDENTIALITY AND RELEASE OF INFORMATION

I agree to the release of personal and financial information from this application form to the agency determining eligibility for the **Prescription Discount Program** so that they can evaluate it and verify eligibility. I understand that I may be asked to provide additional information. Officials of the **Prescription Discount Program** may verify all information on this form. I understand that I must tell the agency that determines my eligibility about any changes in information on this form. By signing this application, I certify under penalty of perjury that everything on this form is the truth.

I certify under penalty of perjury that all applicants for the **Prescription Discount Program** are residents of Anne Arundel County and have no pharmacy insurance coverage.

All information and documentation gathered for determining eligibility is confidential. Disclosure of information concerning my eligibility to anyone not authorized to receive the information is a violation of State and Federal laws.

The application must be signed by an adult household member (age 18 or over).

(Applicant Signature)

(Date)

From: _____

Staple or Tape Here

Place
Stamp
Here

To: **Anne Arundel County Department of Health**
Prescription Discount Program – HD #5
3 Harry S. Truman Parkway
Street Address
Annapolis, MD 21401
City State Zip Code