Ascension Rx Medication Assistance Program Application

Ascension Rx Hickman	150 East Swan Street Centerville, TN 37033	P 931.729.6798 F 931.729.6799
Ascension Rx Midtown	300 20th Ave North, Ste 104 Nashville, TN 37203	P 615.284.6170 F 615.284.6171
Ascension Rx River Park	140 Vo Tech Drive, Ste 2 McMinnville, TN 37110	P 931.815.1340 F 931.815.1341
Ascension Rx Saint Louise	1020 N. Highland Ave Murfreesboro, TN 37130	P 615.396.6167 F 615.396.6627
Ascension Rx West	4230 Harding Pike, Ste A214 Nashville, TN 37205	P 615.222.6216 F 615.222.6189

Applications accepted Monday through Friday 9:00am - 4:00pm

First Name	Middle Initial	Last	Social Security #

Mailing Address	City	State	Zip	Phone

Date of Birth	Age	Male/Female	Drug Allergies

Did you file a Tax Return Last Year? Yes _____ No _____
Are you a Veteran? Yes _____ No _____
Do you receive Food Stamps? Yes _____ No _____
Do you have Medicare or TennCare? Yes _____ No _____ (if yes, please list Medicare/TennCare Number) _____
Has the Social Security Department classified you as disabled? Yes _____ No _____
Do you receive Social Security or Disability Benefits? Yes _____ No _____
Do you have Medical or Prescription Drug Insurance? Yes _____ No _____ (please list) _____
What is your housing status? Rent _____ Own _____ Living with someone else _____ Other: _____
Family Status Single _____ Married _____ Widowed _____ Divorced _____ Other: _____
Work status Employed _____ Retired _____ Disabled _____ Unemployed _____

How much income before taxes & deductions do you earn or receive? per WEEK _____ OR per MONTH _____ OR per YEAR _____ (include wages, social security, pension, alimony, child support, unemployment., etc)
How many people are in the household? _____ Relationship to applicant?_____

How much before taxes & deductions do other people in the household (including spouse or significant other) earn or receive? per WEEK _____ OR per MONTH _____ OR per YEAR _____

PROOF OF INCOME REQUIRED TO PROVIDE ASSISTANCE BEYOND THE FIRST FILL OF MEDICATIONS.
Examples of Proof of income: Tax Return, Paycheck stubs, Food Stamp Eligibility Letter
Application, ID, & proof of income must be provided every 12 months.

I certify that the above information is true and complete to the best of my knowledge. I will notify staff of any changes in employment, income, or insurance status prior to having additional prescriptions filled. If I provide falsified information, my enrollment in the Medication Assistance Program will be revoked and I will no longer be eligible for the program.

_____ _____ ***Rev 1/31/2025***
Signature of patient Date

Office use only

Source of Referral: SS Health Dept Hickman nav Holy Family Magdalene Next Door SLC STFHCW OTHER _____

☐ Enterprise Rx checked ☐ OneSource/Passport checked

Pharmacy Staff Signature: _____ Date: _____