Avamar Foundation

Qualifications:

- Must be 55 years or older
- Must reside and receive treatment in our community
- Must be unable to afford the cost of medications
- Must Provide low income documentation (Federal Income Tax, W-2's, S-1099, etc.)

Alternative resources will be reviewed for the most beneficial outcome

Avamar Foundation Prescription Assistance Application
Last Name: **First Name:** **Middle Initial:**
Street Address:
City: **County:** **State:** **Zip Code:**
Phone: ( ) **Gender:** **Birth date:**
Annual Income: **Source:**
Insurance Company: _____ **ID:**_____ **Phone:**_____ **Prescription Benefit:** _____ **ID:**_____ **Phone:**_____
Physician: **Phone: ( )**
Medication:_____ **Dose:** _____**Quantity**_____ **How often do you take the medication?** _____ **Cost: $**_____

Avamar Foundation

Avamar Foundation Patient Attestation

In consideration for acceptance into the Avamar Foundation program for prescription assistance:

I agree and certify that all the information I have and will provide to the Avamar Foundation in my application for assistance is true and complete.

I agree that the Avamar Foundation and its agent can obtain and discuss medical, financial and other information related to my foundation assistance with my health providers, pharmacies, insurance companies and any other people working on my behalf to obtain prescription medications.

I am not receiving financial assistance for what I have applied for with the Avamar Foundation.

I have read, fully understand and agree to the attestation outlined above.

Signature of applicant: _____ Date: _____

Prescribing Physician

I attest that the above applicant is my patient and I am recommending prescription assistance for:

Patient Name: _____DOB: _____
Medication: _____Dose:_____ Quantity:_____
Instructions: _____

Physician Signature: _____Date:_____

Please fax application to the Avamar Foundation @ 330-372-7480.