MEDICAL ASSISTANCE PROGRAM APPLICATION

Batavia RSVP, Inc. P. O. Box 688, Batavia, IL 60510
630-406-9993
BataviaRSVP.org RSVPBatavia@gmail.com

Applicant's Name_____

Address_____

City_____ State_____ Zip_____

Telephone_____ Birth Date_____

Primary Physician_____City_____ Phone_____

Pharmacy Normally Used*_____ City_____

If approved you must obtain your medications from Osco Drug Pharmacy – Batavia

PLEASE NOTE: ALL INFORMATION GIVEN ON THIS APPLICATION IS CONFIDENTIAL

	Yes	No
• Do you currently have prescription medication under the Illinois Cares or Circuit Breaker Pharmaceutical Program?	O	O
• Do you have insurance other than Medicare that reimburses you, in whole or in part, for the costs of prescription medications?	O	O

- Please list the amount of every portion of your annual income:

Social Security	$_____
Pension	$_____
Interest, Dividends and Capital Gains	$_____
Salary	$_____
Other Sources of Income (e.g., rental, gifts, etc.)	$_____
Total Annual Income	$_____

Note: The following two (2) pieces of information **MUST** be submitted with this application:

1. A copy of your most recent Federal or State Income Tax Return (preferred) or Statement of Social Security Benefits

2. A listing of your out of pocket expenses for prescription medications over the past 12 months. This can be obtained from your pharmacist. (**This is needed for first-time applicants only**.)

I certify that the above information is an accurate and complete disclosure of the requested information.

Applicant's Signature_____ Date_____