Application Date:		
	Approved	Date:
	Declined	Date:

THIRD STREET CLINIC APPLICATION

***Please Print* and complete all applicable sections of the application. If you have questions, please contact a Third Street Clinic Client Advocate at 701-772-1263.**

Name: _____ Date of Birth: ____/____/____

Address: _____ County: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Email Address: _____

Communication preference: ( ) Phone ( ) Text ( ) Email ( ) All methods are acceptable

This form is being completed by:

( ) **Self**

( ) **Relative/Other**
Relationship: _____ Phone Number: _____

( ) **Agency Representative:**
Agency Name: _____ Phone Number: _____

Agency Representative/Title: _____

Section 1. PERSONAL INFORMATION

Gender: ( ) Male ( ) Female ( ) Other **Social Security Number:** ___ - ___ - ___

Marital Status:

( ) Single
( ) Married
( ) Divorced/Separated
( ) Domestic Partner

Education Level:

( ) Some High School: Grade completed: _____
( ) High School Diploma/GED
( ) College/Some College: Semesters completed: _____ Degree: _____

Ethnicity:

( ) African American
( ) Asian
( ) Hispanic or Latino
( ) Native American
( ) White
( ) Other: _____

Section 2. HOUSEHOLD INFORMATION

Type of Household:

(__) Rent
(__) Own
(__) Shelter
(__) Shared Occupancy
(__) Other. Describe _____

Please list all members of your household living with you.

Name	Date of Birth	Sex	Relationship
	/ /		

Section 3. INCOME VERIFICATION INFORMATION

1.Are you employed? (__) YES (__) NO *If no, go to question* 9

2.Employer Name: _____

3.Employer Phone Number: _____

4.(Household Member's) Employer Name: _____

5.(Household Member's) Employer Phone Number: _____

6.Employment Type: (__) Full Time (__) Part Time (__) Season (__) Day Laborer (__) Self-Employed

7.Does your or Household member's employer offer: (__) Insurance (__) Flex Program

8.What is the cost of your portion? $_____per pay period/month

9.Do you or a household member ever serve in the Armed Forces? (__) YES (__) NO

10.Have you spoken with your County Veteran Service Officer? (__) YES (__) NO

Indicate Income from SELF (S) or HOUSEHOLD MEMBER (HM)	Gross MONTHLY Amount
	$
	$
	$

11. How often are you paid? (__) Weekly (__) Bi-weekly (__) Monthly (__) Bi-monthly

12. Is ANY member of your household on leave of absence from work? (__) YES (__) NO

13. Does ANY member of your household receive ANY of the following?

SOURCE OF INCOME	SELF (S) and/or Household Member (HM)	Gross MONTHLY Amount	YES	NO
Unemployment Benefits		$		
Disability Benefits (SSDI or WSI)		$		
Public Assistance (TANF)		$		
Child Support/Spousal Support		$		
Social Security or SSI Benefits		$		
Pension or Annuity Benefits		$		
Rental Income		$		
Regular Contributions from Person/Agency		$		
ANY Income not listed above		$		

14. Are you or ANY member of your household receiving any of the following?

SOURCE OF SERVICES	SELF (S) and/or Household Member (HM)	County	YES	NO
Medicaid				
Medicaid Expansion				
Minnesota Care				
Migrant Health				
WIC				
Medicare				
Private Insurance				

15. Have you applied for any of the above services? (__) YES (__) NO

Which Program(s) have you applied for? _____

16. Date of Application? _____

17. Caseworker's Name: _____

18. Agency: _____

19. Do you need assistance applying for any above services? (__) YES (__) NO If yes, which services would you like help applying for? _____

_____

If you are not employed or zero income, please review the "Zero Income Statement" below.

Zero Income Statement

1. By providing my signature, I declare that I currently do not have any income source. My financial support comes from (please describe):

   _____

   _____

2. I understand that by signing this completed form, I declare that I have no household income and that the information I am providing is correct. I understand that providing false information on this form my result in denial of services.

3. I understand that Third Street Clinic or Inspire Pharmacy is under no legal obligation to provide free or reduced cost prescription medication(s).

4. Signature of Applicant: _____Date: _____

Office Use Only

Verification of Identification:

	Photo ID or Driver's License	Office Use:
	Social Security Card	
	Passport or Visa	
	Military ID Card	
	Other:	

Verification of Income:

	Paystub(s)	Office Use:
	Tax Return	
	Qualifying Letter from Medicaid/Medicare	
	Child Support Statement	
	Other:	

Total Gross Income:	$	Comments:

Section 4. PROGRAM INFORMATION

Programs asking for assistance for: ***Please check ALL that you are applying for.***

	Prescription Medication Assistance Program	Office Use: Has the patient used any coupons or PAPs for any of the requested medications?
	Prescription Medication Co-pay Assistance	
N/A	Over-The-Counter Medication Assistance	
N/A	Nutritional Supplements	
N/A	Other	

Please list medications and dosages requesting assistance for:

Medication(s)	Dose	Reason for Taking: (Diagnosis)

List Prescribing Provider(s): _____

_____

List Transferring Pharmacy: _____

_____

Please list any allergies: _____

_____

How did you hear about Third Street Clinic?

(__) Provider or Agency Caseworker: Name: _____
(__) Printed Brochure
(__) Social Media ***Please indicate*:** (Website, Facebook, Instagram, Twitter or Linked-In)
(__) Television
(__) Radio
(__) Church: Which Church?_____

(__) Other: _____

I understand that Third Street Clinic provides a program for prescription medication assistance for qualifying residents of the greater Grand Forks, North Dakota area including areas located in Minnesota. Assistance is given for those who qualify according to Program Guidelines. I understand the above information and do hereby request and authorize the services offered by Third Street Clinic.

By signing this form, I am give permission for the Release of Information between Third Street Clinic and other providers and agencies involved in my care.

I have read the Program Guidelines.

Signature: _____ Date: _____

360 Division Avenue Suite 101
Grand Forks, ND 58201
Office: (701) 772-1263
Help4You@ThirdStreetClinic.org

Release of Information Form

I (please print): _____

Authorize (name of agency): _____

To release the following information: _____

_____

_____

To: Third Street Clinic

For the following purposes: _____

_____

I may revoke this authorization in writing at any time, except for information which has already been released in accordance with this authorization prior to my revocation.

Signature: _____ Date: _____

Staff signature: _____ Date: _____