Millennium Pharmacy
281-298-1129
Financial Assistance Questionnaire

Patient Name: _____

DOB: _____SS #_____ Date of Diagnosis: _____

Patient Phone _____ Treatment Start Date: _____

Diagnosis: _____

Medications: _____ _____

Number of People in Household (including patient) _____

** Employment Status (circle one) employed unemployed retired disabled

** Receiving unemployment benefits (circle one) yes no

** If yes what date did patient begin receiving benefits? _____

**Annual Income of Household: _____

**Number of People who contribute to Annual Income: _____

Are you a Veteran? (circle one) Yes No

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Other

By signing below:

- I authorize Millennium Pharmacy employees to act as my advocate in applying for Prescription Financial Assistance.
- I authorize (insert person name) _____ _____ to discuss my confidential medical and/or financial information if needed.
- I attest that the information included with this form is accurate.

_____ _____

Patient Signature Date

Please fill out and fax to Millennium Pharmacy Financial Counselor at 281-298-1168

**To save time please have proof of income (either last year's tax return or Social Security Benefits letter) attached to this form.

Please note: Most financial assistance awards are based on income. There is no guarantee that you will receive assistance. It normally takes 3-5 business days to get an answer. Please call the pharmacy if you have questions.