Medication Assistance

The Medication Assistance (MA) provides a link between patient, provider and pharmaceutical companies to provide certain long-term medications free of charge.

Monadnock COMMUNITY HOSPITAL

Your life. Your health. Your Hospital.

Eligibility:

Must have a healthcare provider with Monadnock Community Hospital
- Must have no prescription drug coverage except for Medicare Part D
  - *Certain exceptions may apply for specific medications*

Must meet the drug companies' income guidelines
- *Every drug company has different limits*

Only certain medications are available regardless of other eligibility

How to Apply:

1. **Complete the application on the back of this letter**
2. **Provide income proof as it applies to your household:**
   Copy of your most recent Federal Income Tax Return; required documentation if you still file
   Copy of your Social Security Income
   If you no longer have this information, you can call for a replacement: 1-800-772-1213
   Copy of your 3 most recent pay stubs or unemployment stubs
   Copy of your pension or annuity income
   If none of these apply, please write us a statement regarding your financial status
3. **If you have Medicare Part D Prescription Drug Benefits:**
   A copy of your Medicare Part D Card (front and back)
   IF you have applied and been denied for Medicare's Low Income Subsidy (also known as "Extra Help"), please send us a copy of the denial letter
   A copy of your OOP (Out of pocket) expenses for prescriptions from Jan. 1 through present
   If the Pharmaceutical company has an OOP requirement this is needed
4. **Mail or fax your application to:**
   Monadnock Community Hospital
   Medication Assistance
   452 Old Street Rd
   Peterborough, NH 03458
   Fax: (603) 924-1709

Facts about the Medication Assistance

We cannot help with every medication. The medication assistance is determined by the drug companies, not Monadnock Community Hospital. Medications may occasionally change.

We do not supply medications from this office. Help is not immediate; the medications come directly from the manufacturer, so it may take several weeks for a delivery to arrive.

We might ask for extra information. Some companies require more information before a medication can be shipped. Again, this is a requirement of the drug companies, not Monadnock Community Hospital.

Please feel free to contact us if you have any questions or concerns.

Monadnock Community Hospital
Medication Assistance
452 Old Street Rd Peterborough, NH 03458
Phone: (603) 924-1717 *or* 924-1794 / Fax: (603) 924-1709

05/2025

Monadnock Community Hospital Medication Assistance Application

Name:_____Social Security #: _____-____-_____ DOB _____

Address: _____City: _____ State: _____ Zip: _____

Mailing Address (if different): _____City: _____State: _____Zip:_____

TEL # (HOME): _____ (CELL): _____ # in Household _____

Check all that apply:

☐ Female ☐ Male ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Veteran ☐ NH Resident ☐ US Resident

Do you have any Prescription Coverage? _____ Do you have Medicare Part D? _____Do you have Health Insurance? _____

Insurance and Prescription Company and ID #:_____

Who is your Primary Healthcare Provider (Doctor/PCP)? _____

List any Allergies to medications or medical products: _____

List any Health Conditions (asthma, depression, etc.): _____

_____

ASSETS: (All that apply to the household): Checking Acct(s): _____ Savings Acct(s): ___ retirement/investment(s)_____

Name of Medication:	Strength:	Dose:
1.		
2.		
3.		
4.		
5.		
6.		

Patient Consent and Release for Exchange of Information

Application for the Provision of Care

I certify that the information I have provided in my application is accurate and true to the best of my knowledge and belief. I understand that even if my application is approved, services are not guaranteed. I also understand that other documents will be required to provide proof of income. I give permission to verify my income through the Department of Social Services, Social Security Administration, my employer, Internal Revenue Service, Veterans Administration and any other company, business, or organization from which I receive income.

By signing the enclosed application, I authorize representatives of Monadnock Community Hospital Medication Assistance to ask necessary information of my health care providers, to complete applications for medication assistance and to share this information with pharmaceutical companies as required.

Patient Signature Authorization

I give permission to the representative of the Patient Assistance Program to sign patient assistance program applications for me on my behalf. This consent is valid as long as I am a patient of Monadnock Community Hospital Medication Assistance or until I revoke my permission in writing.

_____

Signature Date