Medication Voucher Program

Hardship Qualification Form

Name (print)		**Gender**	**Date of Birth**
Address		**Telephone Number**	
City	**State**	**Zip Code**	

Are you currently a resident of the state of Iowa?	Yes	No
I do NOT have insurance coverage for Prescription Drugs.	Yes	No
Are you currently enrolled in a Medicare Part D program?	Yes	No
If "yes" to the above, are you currently in the donut hole in coverage?	Yes	No
Do you have transportation available to travel to a participating pharmacy?	Yes	No
Are you unemployed? If "yes" for how long?_________________	Yes	No

Signature of Applicant or Representative **Date**

Signature of Agency Submitting Hardship Qualification **Date**

By my signature, I certify that all information on this form is accurate and complete. I understand the Iowa Prescription Drug Corporation may contact me in the future to verify this information. If the information I have provided is incomplete or inaccurate, and I do not meet the eligibility requirements any services I request may be denied.

Check for participating Pharmacies at www.iowapdc.org.

Form continues on back

Patient Information

Name:____

Medication - Prescription, Over-the-counter, Herbal	**Strength**	**Quantity Per Day**

Are you allergic to any medications? Yes No

If yes please list: ____

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List any major medical conditions: ____

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Name of Physician: ____________________________ **Phone:** ____________________