



2700 Middleburg Drive, Suite 105  
Columbia, SC 29204  
800.763.0059

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Personal Mailing Address: (no P.O. Box): \_\_\_\_\_ Race: \_\_\_\_\_ Gender: Male  Female  Are you a legal resident? Yes  No

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Alternative Phone: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Healthcare Phone: ( ) \_\_\_\_\_

Healthcare Provider Address: \_\_\_\_\_

List all allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2010 HHS Poverty Guidelines	
Persons in Family Or Household	Maximum Annual Household Income
1	\$21,660
2	29,140
3	36,620
4	44,100
5	51,580
6	59,060

For each additional person add \$7,480

**PATIENT ELIGIBILITY INFORMATION**  
**ATTACH ANNUAL GROSS HOUSEHOLD INCOME (REQUIRED)**

**MONTHLY GROSS HOUSEHOLD INCOME** (include proof of all income, wages (2 consecutive weeks on pay stubs), social security, pension, disability, retirement, child support, annuity, alimony statement, rental income, workers' comp, unemployment, etc.)

Number of people in household: \_\_\_\_\_ \$ \_\_\_\_\_ **MONTHLY GROSS HOUSEHOLD INCOME**

Do you have: (please check)  Health Insurance  Medicare  Medicaid  Family Planning  VA Health  No Health Benefits

**STATEMENT OF RELEASE**

I attest that the above information is complete and accurate. By my signature, I authorize the release of the information about me and my medical condition to Welvista and/or their agents. I authorize Welvista and/or their agents to use and disclose such information for the assessment of my eligibility for and enrollment into the Welvista program, which may include contacting and providing information to social workers, state agencies, healthcare providers or other persons or entities Welvista may deem appropriate to release medical records or required information bearing on my eligibility and benefits under the program. Additionally, I agree that at any time during my enrollment Welvista may request additional documentation to authenticate the statements made on my application. I will notify Welvista if I become eligible for Medicare, Medicaid, Health Insurance, VA Health Benefits, or if there is a change in my financial status.

I have received Welvista's Notice of Privacy Practices Statement  
*My signature below indicates that I have chosen to opt out of child proof caps.*

**Patient/Guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

I authorize Welvista to ship my medications to: Name of Patient Agent (name of person) \_\_\_\_\_

- BEFORE YOU MAIL**, be sure that you have included:
- \$20 MONEY ORDER** (non-refundable)
  - PROOF OF INCOME** for **ALL HOUSEHOLD MEMBERS**
  - SIGNED AND DATED** the application

**Welvista Use Only**

Approved/Denied: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Approved Date: \_\_\_\_\_

Paid: \_\_\_\_\_



Dear Applicant,

Thank you for your interest in the Welvista Medication Assistance Program. Attached you will find the application form for you to complete.

Welvista provides access to medications for qualified patients. Qualifications are determined according to guidelines established by Welvista and in accordance with our 12 pharmaceutical partners as well as state and federal guidelines.

To participate in our program, it is important that you complete all requested information and sign where indicated. Incomplete or incorrect applications will delay the application process so please ensure all information provided is correct.

**PATIENT REQUIREMENTS:**

- Complete and sign the Welvista application.
- Attach a photocopy of the **MONTHLY** gross household income. (i.e. Federal tax form (1040), social security income (SSA 1099), pensions, annuity, rental income, retirement, alimony statement, child support statement, statement of income from employer, unemployment, workers' comp, s.s. disability, with entitlement letter)
- \$20 non-refundable processing fee (money orders only)
- Cannot have any form of Health Insurance, Medicare, Medicaid (except Family Planning) or Veterans' Health Benefits
- Must be a legal resident of South Carolina or qualify under the guidelines of the Out-of-State Pilots
- Household must be at or below 200% of the Federal Poverty Guidelines

**SUBMIT COMPLETED APPLICATION BY SELECTING ONE OF THE FOLLOWING OPTIONS:**

- **MAIL:** Welvista, 2700 Middleburg Drive, Suite 105, Columbia, SC 29204
- **FAX:** 1-877-731-2557 (can only accept faxes from organizations that are invoiced)

Enrollment in program is for up to one (1) year and you are eligible for all medications on our formulary. Patient will be notified prior to renewal date.

Once application is received, it will be reviewed and your eligibility for participation in the Welvista Medication Assistance Program will be evaluated. You will be notified by mail upon completion of our review and evaluation. Please note that program rules are subject to change without notice.

If you are approved for the program, prescriptions are filled for a 90 day supply unless you are ordering a medication that is limited to a 30 day supply. Medication(s) will be shipped as designated on the application. Your doctor may write for refills for your medication(s). The patient must request a refill 10 days before prescription(s) run out by calling 1-800-983-3339 and following the recorded instructions on our IVR line. Please note that Welvista cannot contact your doctor for additional refills.

If you have any questions or need further assistance, please call 1-800-763-0059, between 8:30 a.m. and 5:00 p.m. Eastern Time, Monday through Friday. Please visit our website at [www.welvista.org](http://www.welvista.org).

Sincerely,  
Welvista