Contact us:
Monday- Friday 8:00am-4:30pm
Local: 704-536-1790
Toll Free: 866-331-1348
Fax: 704-536-9865
Email: info@medassist.org
www.medassist.org

Free Pharmacy Program Application Instructions

Thank you for your interest in the NC MedAssist Free Pharmacy Program. NC MedAssist is a non-profit pharmacy that provides free prescription medication to North Carolinians struggling with medication access.

To qualify:

- You must live in North Carolina.
- Your income must be at or below 300% of the Federal Poverty Level.
- No health insurance.

We may be able to help if you have Medicare on a case-by-case basis. Please contact us.

2025 Federal Poverty Level		
# in Household	Monthly Income	Annual Income
1	$3,912	$46,950
2	$5,287	$63,450
3	$6,662	$79,950
4	$8,037	$96.450
5	$9,412	$112,950
6	$10,787	$129,450
7	$12,162	$145,950
Each additional person add	$1,375	$16,500

You do not need a prescription to enroll into the program.

There is more than one way to apply. Choose from one of the following:

1. Apply online. Go to www.medassist.org and click on "How to Enroll."
2. Call us and request a paper copy or go online and download the application. Just fax or email it back to us.

    - **Mail** to NC MedAssist, 4428 Taggart Creek Rd, Suite 101, Charlotte, NC 28208
    - **Fax** to 704-536-9865
    - **Email** us at info@medassist.org

What happens after you apply?
Please allow 7-10 business days for processing your application, filling your medication and shipping it to your address. Once approved, you may be enrolled into the program for **up to one year**. You must re-apply every year to remain in the program.

Your medications will be shipped from our pharmacy in Charlotte, NC and mailed to the address listed on your application or a Point of Entry (POE) partner.

NC MedAssist does not automatically refill prescriptions. **You must call in your refill 7-10 days before you run out of medication**. For questions about your medication or to reach the 24-hour refill line, please call the pharmacy at 704-943-9639 or 866-331-1348.

Where to send prescriptions: Doctors can e-scribe prescriptions directly to our pharmacy or fax us at 704-536-9812. Copies, lists, and transfers are not accepted. For questions, call the pharmacy at 704-943-9639 or 866-331-1348.
We must have your application and supporting documents in order to approve you for the program. If you submit just the application, we will only enroll you for 60 days. Below is a list that

includes, but is not limited to, the type of documents that you can send with your application. We may accept other documents on a case-by-case basis.

Application Complete and sign your name.

Proof of Address Examples include: State ID with current address, utility or medical bill, lease, food stamp letter, Medicaid Denial, Medicare Denial, or any government issued letter. Address must include your name and must match the address listed on your application.

Proof of Current Income- Income documents must be dated from within the last 60 days. If married, include income of spouse. If spouse has no income, see below. Annual statements must be dated this year. Please submit all documents that apply.

- **Job**- Submit a month of consecutive pay stubs dated (4 pay stubs if paid weekly, 2 if paid bi-weekly, 1 if paid monthly).
- **Income Verification Form-** If you cannot obtain check stubs, please have your employer complete the following document.
- **Self-Employment Form-** Submit this form if you are paid in cash.
- **VA benefits, workers comp, work first, short term disability, retirement or pension income**- Submit a monthly or annual statement for the current year.
- **Social Security**- Submit a current year statement. Include a "Notice of Award" if you receive Social Security Disability. (1099's not accepted).
- **Child support**- Submit a statement with current amount received in the last month.
- **Unemployment benefits**- Submit proof of Employment Security Commission unemployment benefits from within the last month.

To request any of the supporting income documents listed below, please call us or visit our website at www.medassist.org and click on "How to Enroll."

- **Letter of Support/Zero Income Statement**- If you are not currently working, you will need to have the person who is providing you with support sign the support letter. Support includes, room and board or paying of rent, utilities, groceries, etc. Spouses with no income must complete the Zero Income Statement.
- **Documentation of Homelessness**- If you are homeless with no support and/or move from place-to-place, complete this form.
- If you are a resident in a **shelter or treatment program**, attach a letter stating you live there.

Tax Filing: You do not need to submit any documentation if you **do not** file taxes. If you or your spouse files taxes, include the 1040 tax return. See below for details. No W-2's accepted.

- **1040-** If you file taxes, please provide the two pages of the 1040 from your most recent federal income tax return. Please sign and date your tax return. If you are self-employed or receive other taxable income, please attach the Schedule 1, C, D, E, or F.

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NC MedAssist Free Pharmacy Program Application

Please complete pages 1-3. Sign your name on page 3 and submit with your supporting documents. See previous page for application instructions.

Patient Information

First Name:	MI:	Last Name:	SSN /ITIN(W-7):	Birth Date:
Mailing address:		City:	State: **NC**	Zip:
County in North Carolina:		Primary Phone #:	Emergency Contact Name/Phone/Relation:	
Please list any medication allergies that you have:		Email Address:		

Demographics

Check all that apply: ☐Disabled ☐LGBTQIA+ ☐Veteran or Military Family ☐Justice-Involved

Primary Language(other than English): ☐Spanish ☐Chinese ☐French ☐Arabic ☐Vietnamese ☐German ☐Hindi ☐Telugu ☐Russian ☐Korean ☐Portuguese ☐Tamil ☐Hmong ☐Tagalog ☐Other:

Gender: ☐Male ☐Female ☐Non-binary

Marital Status: ☐Single ☐Married ☐Separated

Race: ☐ White or Caucasian ☐ Black or African American ☐Asian ☐American Indian ☐ Bi-racial of Multi-racial ☐Native Hawaiian or Pacific Islander ☐ Other:

Number of People in Household Including Self: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 Other:

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

How did you hear about the program? ☐ Doctor/Clinic/Hospital ☐ Flyer ☐Friend/Family ☐ Facebook ☐ Event ☐ Other:

Please check if you have any of the following: ☐Health Insurance ☐ Medicare ☐Medicare Part D ☐ Medicaid ☐VA Health ☐Other

If applicable, Name of Enrollment Site or Sponsoring Point-of-Entry(Enter site code):

Do you struggle with substance use? ☐Yes ☐No
If yes, are you interested in receiving help? ☐Yes ☐No

Do you use tobacco(smoking, vaping, chewing)? ☐Yes ☐No
If yes, are you interested in quitting? ☐Yes ☐No

Patient Income

List and Attach all Household Income:

Salary/Wages	$_____
Disability	$_____
Alimony/ Child Support	$_____
Social Security	$_____
Pension/Retirement	$_____
Unemployment/Work Comp	$_____
Gross Monthly Income	**$**_____
Total Gross Annual Income	**$**_____

Attach Proof of Income or No Income
Please see the application instructions to find a list of approved income documents. If married, please include income of spouse.

All income must be dated from within the last 60 days. Annual statements must be dated this year.

Did you file taxes this year?
☐Yes ☐No

Next, you will find our Health Survey that must be submitted with your application. The information we gather from these surveys helps us to get funding for NC MedAssist and continue providing you with medications you need at no cost. Your responses allow us to tell how this service improves your health and quality of life. Please answer the questions to the best of your ability by circling, checking or filling in your answer.

Section I. Physical Health

1. Prescription Medications

    a. Are you taking all the medications as prescribed by your doctors?
    ☐Yes ☐No

    b. Do you skip taking medications as prescribed by your doctors?
    ☐Yes ☐No ☐Sometimes

2. In the past year, how many times did you go to the emergency room? _____ times

3. In the past year, how many times did you stay overnight in the hospital? _____nights

4. How would you rate your current health?

    1 - Poor 2 - Fair 3 - Good 4 - Very good 5 - Excellent

5. In the past year, how much were your physical health activities limited due to health problems?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

Section II. Finance/Employment

6. Are you currently employed? ☐Yes ☐No

    If yes,
    a. How many hours do you work per week? _____

7. How much do you struggle to cover basic living expenses (e.g., food, housing, transportation, bills)?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 – Extremely

Section III. Social/Emotional Health

8. How would you rate your quality of life right now (by that we mean your emotional well-being, life satisfaction and/or happiness)?

    1 - Poor 2 - Fair 3 - Good 4 - Very good 5 - Excellent

9. In the past year, how much have you been bothered by emotional problems (such as feeling anxious, depressed, isolation, or irritable) because you can't afford your medications?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

10. In the past year, how much has your daily routine been affected (ex. Unable to do your usual tasks/activities at home and/or at work)?

    1 - Not at all 2 - A little bit 3 - Somewhat 4 - Quite a lot 5 - Extremely

Section IV. General Questions (Optional)

11. Because I need to pay for my medication, I have not been able to pay for: (mark all that apply*)*

☐ Groceries
☐ Basic living expenses (rent, utilities, bills)
☐ Money into a savings account
☐ A car payment or for transportation
☐ Other bills
☐ Others (please list): _____

Applicant's Agreement/Disclosure/Release

I attest that the information I have given in this enrollment application is accurate and true. I also understand that even if my application is approved, services are not guaranteed. By signing this application, I release NC MedAssist, its affiliated drug companies and any public or private agencies or financial supporters and their agents, from any and all claims of liability in contract or tort arising out of the actions of NC MedAssist, its agents, employees, or P.O.E in performing services or related to services I receive from NC MedAssist. I give my consent to DSS and DHHS to advise NC MedAssist of the status of a pending Medicaid application. **I will promptly notify NC MedAssist if I become eligible for Medicare, Medicaid, private insurance or VA benefits, or if my income changes**. I also give consent to NC MedAssist to disseminate my health information to its affiliates (i.e. audits by pharmaceutical companies) as it pertains to all federal, state and local laws and regulations and purposes directly related to the administration of NC MedAssist programs and grants. I hereby authorize NC MedAssist and its designated representatives to utilize a third-party electronic income verification system to verify my household income and address for the purpose of determining my eligibility. I have received NC MedAssist's Notice of Privacy Practices Statement. I give my permission to NC MedAssist to sign my name on Patient Assistance Program documents when necessary.

Patient Signature_____Date_____

For Office Use Only

*Patient ID*_____

Date Entered_____ Temp Date_____ Recert Date_____ POE_____

NC MedAssist Employee Signature_____ Date_____