



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 for free medications**. 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.

PLEASE NOTE: If a name-brand medication is needed, additional documentation is required.

Below is a list that includes, but is not limited to, the type of documents that you can submit. 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.

Questions? Call 866-331-1348



Free Pharmacy Program Application

4428 Taggart Creek Rd
Suite 101
Charlotte, NC 28208
Toll Free: 866.331.1348
Local: 704.536.1790
Fax: 704.536.9865
www.medassist.org

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:		Attach Proof of Income or No Income
Salary/Wages	\$ _____	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Disability	\$ _____	
Alimony/ Child Support	\$ _____	
Social Security	\$ _____	
Pension/Retirement	\$ _____	
Unemployment/Work Comp	\$ _____	
Gross Monthly Income	\$ _____	
Total Gross Annual Income	\$ _____	

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

Patient ID: _____

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, 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
- Money into a savings account
- Other bills
- Basic living expenses (rent, utilities, bills)
- A car payment or for transportation
- 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 am app 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 _____

<i>For Office Use Only</i>		
Date Entered _____	Recertification Date _____	POE _____
NC MedAssist Employee Signature _____		Date _____

Notice of Privacy Practices

NC MedAssist values your privacy. This notice explains what information we collect, how we use it, and how we protect it.

What We Collect

To provide you with free prescription medications, we may collect:

- Proof of income (such as tax returns, pay stubs, Social Security letters, or letters of support)
- Prescriptions written by your healthcare provider
- Basic personal information like your name, date of birth, gender, address, and phone number
- Photograph or biography if needed for identification or program purposes

We may also ask you to complete a health survey. These surveys do not collect your name or personal identifiers and are used only to measure how our services help the community.

How We Use Your Information

- NC MedAssist partners with many pharmaceutical companies, each with their own eligibility rules.
- Your file may be reviewed (audited) by these companies to ensure we follow their requirements.
- These reviews are required for us to provide you with free medications.

Your Information Is Never Sold or Shared for Marketing

We do not sell or share your personal information. We will never share your personally identifiable information or protected health information (PHI) with any outside organizations, including but not limited to:

- Government agencies
- Funders or foundations
- Marketing or media companies

Your data is used only to help us provide your medications and meet required program rules.

Occasional Contact

We may contact you to ask if you'd like to share a story or testimonial about your experience. You may choose to say yes or no—your care will never be affected by your decision.

Questions?

If you have any questions about how your information is used, please call us at 704-536-1790.