200% FEDERAL POVERTY GUIDELINES

MEDICAL PRESCRIPTION PROGRAMN

(Effective May 2019)

Per Household

If your household income is at or below the annual and monthly income level you may qualify. These numbers are based on the number of people living in your home (household size) and 200% of the Federal Poverty Level Guidelines (Maximum Income Level).

Family Size	Annually	Monthly
1	$24,980.00	$2,081.67
2	$33,82000	$2,818.33
3	$42,660.00	$3,555.00
4	$51,500.00	$4,291.67
5	$60,340.00	$5,028.33
6	$69,180.00	$5,765.00
7	$78,020.00	$6,501.67
8	$86,860.00	$7,238.33
*For Each Additional Person Add:	$8,840.00	$736.67

COMMUNITY SERVICES AGENCY

Shelby County Community Services

SHELBY COUNTY COMMUNITY SERVICES AGENCY
MEDICAL PRESCRIPTION PROGRAM

REQUIRED DOCUMENTATION

- ☐ SOCIAL SECURITY CARDS FOR EACH HOUSEHOLD MEMBER
- ☐ VALID GOVERNMENT ISSUED IDENTIFICATION
- ☐ PROOF OF ALL HOUSEHOLD INCOME FOR THE LAST 30 DAYS FOR **ALL MEMBERS OVER THE AGE OF 18**
- ☐ MEDICAL PRESCRIPTION SCRIPTS/ PHARMACY PRINTOUT

REQUIRED DOCUMENTATION OF INCOME

SOCIAL SECURITY, SSI, PENSION, DISABILITY AND VA BENEFITS

- ☐ CURRENT AWARD LETTER
- ☐ CURRENT PRINTOUT FROM SOCIAL SECURITY ADMINISTRATION OFFICE

TANF/AFDC INCOME

- ☐ CURRENT DISPOSITION PRINTOUT FROM DEPARTMENT OF HUMAN SERVICES
- ☐ CURRENT LETTER STATING ELIGIBILITY RECEIVED BY MAIL. THE LETTER SHOULD INCLUDE BENEFIT AMOUNT.

CHILD SUPPORT

- ☐ CURRENT PRINTOUT FROM JUVENILE COURT WITH THE **GROSS AMOUNT COLLECTED** MONTHLY
- ☐ CURRENT OUT OF STATE CHILD SUPPORT – LEGAL COURT DOCUMENT WITH STATE SEAL

UNEMPLOYMENT BENEFITS

- ☐ CURRENT PRINTOUT FROM STATE OF TENNESSEE (CLAIM SUMMARY), INCLUDING STATES OUTSIDE OF TENNESSEE

EMPLOYMENT

- ☐ CHECK STUBS FROM EMPLOYER – **IN ORDER BY DATE RECEIVED**
  - **LAST 30 DAYS OF PAY**
- ☐ CURRENT LETTER VERIFYING GROSS WAGES (PAY RATE, HOURS WORKED PER WEEK, PAY DATE)
  - MUST BE SIGNED AND DATED
  - MUST BE ON 8 ½ X 11 COMPANY LETTERHEAD

ZERO INCOME

- ☐ COMPLETE SELF-DECLARATION OF ZERO INCOME FORM-ALL MEMBERS 18 YEARS OF AGE AND OLDER (PROVIDED UPON REQUEST)
- ☐ WRITTEN STATEMENT VERIFYING ZERO INCOME FROM FRIEND OR FAMILY MEMBER THAT IS NOT LIVING IN THE HOME AND HAS NOT APPLIED FOR LIHEAP.

SELF EMPLOYED

- ☐ CURRENT/PRIOR YEAR TAX RETURN
- ☐ SELF-EMPLOYMENT FORM (PROVIDED UPON REQUEST)

COMMUNITY SERVICES AGENCY
Shelby County Community Services

Revised: 3/20/20

Email completed applications to **CSBG@ShelbyCountyTN.gov** or mail application to **2670 Union Extd Suite 500 Memphis, TN 38112**

DATE_____/_____/_____

SHELBY COUNTY COMMUNITY SERVICES AGENCY

MEDICAL PRESCRIPTION PROGRAM
2670 UNION AVENUE EXTD, 5th FLOOR
MEMPHIS, TN 38112
(P) 901-222-4200 (F) 901-222-4242

CLIENT'S NAMES: _____

CLIENT'S DOB: _____/_____/_____ SOCIAL SECURITY#_____

CLIENT'S ADDRESS: _____APT#_____

CITY _____ STATE_____ ZIP CODE_____

PHONE#_____CELL PHONE#_____

PHYSICIAN'S NAMES: _____

CHOSE YOUR PREFERRED PHARMACY:

☐ **MADISON PHARMACY**
1350 CONCOURSE AVE, #111
MEMPHIS, TN 38104
901-321-5530

☐ **THE MEDICINE SHOPPE**
4770 KNIGHT ARNOLD RD
MEMPHIS, TN 38118
901-363-075

COMMENTS: _____

_____

Customer Signature: _____ _____/_____/_____
SIGNATURE DATE

To Be Completed By Office Only:

	MEDICATION	QUANTITY	STRENGTH	RX NUMBER	PRICE
1.					
2.					
3.					
4.					
5.					
6.					

GRAND TOTAL $_____

PRARMACIST/PHARM TECH'S SIGNATURE _____ ____/____/_____ _____
SIGNATURE DATE TIME

CSA Staff Signature: _____ _____/_____/_____
GNATURE DATE

Email completed applications to **CSBG@ShelbyCountyTN.gov** or mail application to **2670 Union Extd Suite 500 Memphis, TN 38112**

APPLICATION FOR CSBG SERVICES

♦Community Services Block Grant♦

SERVICE APPLYING FOR: ☐ NUTRITION ☐HEALTH ☐EMERGENCY SERVICES ☐OTHER
☐ EMPLOYMENT ☐EDUCATION ☐INCOME MANAGEMENT ☐HOUSING

For Agency Office Use Only
DATE APPLICATION RECEIVED:_____
DATE APPLICATION COMPLETED:_____
APPLICATION STATUS: APPROVED DENIED

Applicant Name (first & last): **Telephone:** **Cell:**

Current Address: **City:** Memphis **State:** TN **Zip:**

County: Shelby **Email:**

Mailing Address (If different from Current Address): **City:** **State:** **Zip:**

LIST ALL HOUSEHOLD MEMBERS (INCLUDING APPLICANT- Begin with applicant, then spouse, then oldest child, etc.). USE ADDITIONAL PAPER IF YOU NEED MORE SPACE

NAME (must provide first and last name)	MARITAL STATUS	RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX	RACE *(Optional to Provide)* White, Black, Hispanic, Asian/Pacific Islander, Native American, Native Alaskan, Other - define	VETERAN	HIGHEST GRADE OF SCHOOL COMPLETED	DOES HOUSEHOLD MEMBER RECEIVE REGULAR FINANCIAL ASSISTANCE FOR A PERMANENT DISABILITY?	HAVE YOU PREVIOUSLY RECEIVED ASSISTANCE FROM THIS AGENCY?	RECEIVE FOOD STAMPS, SUPPLEMENTAL SECURITY INCOME, FAMILIES FIRST CASH ASSISTANCE (INDICATE ANY RECEIVING)
Household Member:		Self						Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	
Household Member:								Y or N		Y or N	Y or N	

HOUSING (please check one) ☐OWN ☐ RENT ☐ SECTION 8 ☐ PUBLIC HOUSING AUTHORITY ☐ HOMELESS ☐ HUD

CHILD CARE: Do you have child care? Y or N Is it reliable? Y or N

☐ I don't have any children. ☐I pay for childcare: $_____/ week. Type of care:_____. ☐I have subsidized childcare.
☐ A friend or family member provides childcare. ☐My child / children participate in Head Start/Early Head Start. Which location?
☐ My child/children are in school with appropriate after school care. ☐My child/children are in school without appropriate after school care.
☐ I do not have affordable child care options. Other:_____.

HEALTH: Do you have health insurance? Y or N

☐ I have medical insurance provided by my employer. ☐ My household members have medical insurance provided by my employer. ☐I am provided sick leave benefits.
☐ I have a retirement plan. ☐My household members have TennCare, Medicaid, Medicare, or some other medical insurance provided by the government.
☐ I do not have medical insurance. ☐ My household members do not have medical insurance. ☐I have supplemental prescription assistance to help pay for medications.
☐ I have a copay for my medications. ☐I do not have supplemental medical insurance to help pay for medications.
☐ I (or any household members) often go without my medication due to lack of money. ☐Other:
☐ I have a medical condition that affects my ability to contribute to my household. If so, please explain:

NUTRITION: Does your family experience food insecurity for 1 or more times throughout the month? Y or N Is satisfied through food banks / commodities? Y or N

SUPPORTS: Do you have other family, community, or agency supports? Y or N If yes, please explain

TRANSPORTATION: Do you have transportation Y or N? Is it reliable? Y or N?

EMERGENCY NEEDS: ***I am currently in need of the following emergency assistance:***

HOUSEHOLD TOTAL INCOME (Below list income information for applicant and all household members). Use additional paper if more space is needed.

NAME	SOURCE OF INCOME ☐ Employment ☐SS / SSI / VA ☐TANF ☐ Child Support ☐ Unemployment ☐ Other	FT / PT	HIRE DATE	GROSS MONTHLY INCOME	IF EMPLOYED, PROVIDE EMPLOYER'S NAME & ADDRESS	Is the income reliable?
						Y or N
						Y or N
						Y or N
						Y or N
						Y or N
						Y or N

SOURCE OF INCOME:
►NOTE: ***YOU MUST ATTACH INCOME DOCUMENTATION FOR EVERY PERSON IN HOUSEHOLD*** **◄**

CSBG STATEMENT OF NEED

Please tell us why you need assistance on the lines below: (please print)

_____

_____

Please tell us how you plan to address your situation going forward, what are your goals?

_____

_____

Applicant Certification:

I certify that all of the information provided by me is true and correct. I authorize the verification of any and all information provided herein to determine my eligibility, and acknowledge I have been informed of the appeal process. I understand that I will be notified in writing of my eligibility status. Identifying information provided by you for determination of your eligibility for CSBG and for the provision of services from the program will be considered confidential, unless otherwise authorized or required by law, will not be shared with any other persons or agencies except for the purposes directly related to the administration of the CSBG program. I attest under penalty of perjury that all persons applying for or receiving aid are either a United States citizen or qualified alien as defined by 8 U.S.C § 1641(b), or eligible immigrants. I swear under penalty of perjury (a crime for lying under oath) and all other applicable penalties that the statements made on this application, any attachments, and to whoever interviewed me are true and correct. I understand that anyone who fraudulently covers up a material fact or who knowingly gives false information for the receipt of CSBG assistance is liable upon conviction of a fine of $10,000 or imprisonment for not more than five years, or both.

I DO_____OR DO NOT _____ AGREE THAT THE INFORMATION CONTAINED IN MY APPLICATION MAY BE SHARED WITH OTHER AGENCIES FROM WHICH I SEEK ADDITIONAL SERVICES.

APPLICANT SIGNATURE: _____ Date: _____

If Representative for Applicant, give relationship and reason for signing: _____

NO PERSON ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, AGE, DISABILITY, ANCESTRY, STATUS AS A VETERAN, OR ANY OTHER CHARACTERISTICS PROTECTED BY FEDERAL, STATE, OR LOCAL WILL BE EXCLUDED FROM PARTICIPATION IN, OR BE DENIED BENEFITS OF, OR BE OTHERWISE SUBJECTED TO DISCRIMINATION IN THE OPERATION OF THE CSBG PROGRAM.

To Be Completed By Agency Staff Only:

Number in Household: _____
Total Monthly Income: _____
Total Annual Income _____

DATE/TIME TAKEN: _____

Eligibility:

Method of Eligibility: *Verification or Self-Declaration*
Customer Notification: *Verbal or Written*

National Goal: #1_____#6_____
Goal Was: *Achieved Maintained Not Achieved*

Eligibility Period:_____/_____/_____to_____/_____/_____

Explain: _____

INTAKE WORKER SIGNATURE: _____ ***DATE CERTIFIED:*** _____

SIGNATURE OF DETERMINING AGENCY OFFICIAL: _____ ***DATE:*** _____

Release of Information

This is to confirm that I do hereby give permission to Shelby County Government Comprehensive Emergency Assistant Program to share and/or secure any information necessary to certify me for the CSBG Emergency Cash Assistance Program. I understand that this information will only be shared, secured, or verified professionally while protecting my rights to confidentiality. I also hereby grant the Agency permission to secure additional resources on my behalf, if necessary and appropriate. I do request, however, that _____not be contacted.

Access to Client Records

I further acknowledge that I am aware that Program Supervisors and/or Managers, DHS Auditors, and State Comptroller Auditors will have access to my client records.

Initial _____

Reliability of Information

I also certify to the best of my knowledge that all information provided by me in this approval process is accurate and true. I am completely aware that anyone who knowingly covers up a material fact or gives false information for eligibility determination is liable for prosecution under applicable criminal law.

Initial _____

Grievance Procedures

As a client applying for assistance through Shelby County Government Community Services Agency, you have the right to appeal and request a fair hearing. You must contact the Agency for the proper complaint form. A complaint for must be filled out triplicates and completed within 30 days. After a decision has been made, you, the Agency and the State will retain a copy of the complaint form. The Administrator will contact the Department of Human Services for a final decision if you are not satisfied after a local hearing.

Initial _____

Follow Up Notification

I certify that I have been informed and understand that Shelby County Government Community Services Agency may conduct a follow-up assessment after my initial certification for CSBG services. I agree to provide all necessary requested information for assessment. I certify that I have provided names of two people who will know how to contact me during the next year.

Initial _____

Title VI Compliance

I certify that I have been informed of the Title VI Civil Rights Act of 1964 which states no person will be discriminated against based on age, race, sex, color, religion, or national origin under any program provided by Shelby County Government Community Services Agency.

Initial _____

Citizenship

I certify that at least one adult member of my household is a citizen of the United States of America.

Initial _____

Release of Medical Information (HIPAA-Health Insurance Portability and Accountability Act)

I_____, agree that my medical information may be disclosed to Shelby County Government Communities Agencies and affiliates and also shared with other service provider (s) any agreeing CSA partner agencies concerning assistance for this program.

Client Signature _____ Date _____

Staff Signature _____ Date _____

Email completed applications to **CSBG@ShelbyCountyTN.gov** or mail application to **2670 Union Extd Suite 500 Memphis, TN 38112**