MARTIN COUNTY HUMAN SERVICES
435 SE FLAGLER AVE., STUART, FL 34994
Phone: 772-288-5786 Fax: 772-223-4829

Emergency Prescription Assistance Application

Thank you for contacting the Martin County Board of County Commissioners to request assistance. This packet includes basic information outlining the documentation that you **must provide to be considered for assistance**.

Once you have collected the required documentation listed below, please call **(772) 288-5785** for an appointment. If you do not qualify for assistance, you may call and inquire as to the reason(s) for denial.

Eligibility Criteria

- Must be a Martin County resident
- Must have an emergency need for assistance with the cost of new prescription(s) *(program does not pay for refills)*
- Prescription(s) must be for non-narcotics *(program does not pay for narcotics)*
- Applicant must prove they are below 150% of the federal poverty level
- $200 maximum assistance limit
- Qualified applicants can only receive assistance from this program once every 12 months

Required Documents

Please make sure you **bring originals or copies of the following documentation** in order to determine program eligibility:

- Picture identification for all adults in the household, 18 years of age or older.
- Social Security Cards for all household members.
- Proof of current employment (pay stubs for the last 30 days, or if new hire, letter from employer indicating rate of pay and hours to be worked)
- Copies of official documentation showing **ANY and ALL** other income, such as Child Support, Social Security, Unemployment, Worker's Compensation, Food Stamps, etc.
- Original Prescription(s) *(program does not assist with refills or narcotics)*

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED

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INCOME GUIDELINE

2025 Income Limits

Poverty Guidelines, 48 Contiguous States (all states except AK & HI)

Monthly Income

Household Family Size	150%
1	$1,956.25
2	$2,643.75
3	$3,331.25
4	$4,018.75
5	$4,706.25
6	$5,393.75
7	$6,081.25
8	$6,768.75
9	$7,456.25
10	$8,143.75

Income in this case means gross wages, and certain unearned income such as Social Security Benefits, Alimony, etc. Total gross income must be less than 150% based on your household size to qualify and is based on the last 30 days.

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Applicant Name: _____ **Date:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone: _____ **Email:** _____

*Please list **ALL** household members. Income is calculated based on **gross income** (before deductions), please use exact numbers and use the check box when applicable.*

Household Members	Social Security Number	Relationship	Sex	Disabled	Veteran	DOB	Age	Monthly Income	Income Source	Migrant Worker
		HOH	☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐
			☐☐	☐	☐					☐

Household Size: _____

Total Monthly Income: _____ **x 12 = Annual Household Income**: _____

By signing below, you certify that all information provided is accurate to the best of your knowledge.

Applicant Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

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This document may be reproduced upon request in an alternative format by contacting the County ADA Coordinator (772) 288-5400, Florida Relay 711, or by completing our accessibility feedback form at www.martin.fl.us/accessibility-feedback.

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Describe **in detail** in the space below the reason you are unable to afford your prescription(s).

Describe **in detail** in the space below why it is an emergency that you need your prescription(s).

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CLIENT CONSENT FOR DATA COLLECTION AND RELEASE OF INFORMATION

This client notice and consent describes how information about you may be used and collected for the purpose of providing the service you have applied for and how you can have access to this information. In order for a service to be provided, this form **MUST** be signed.

I, _____, understand and acknowledge that Martin County Human Services uses a digital client tracking system and I consent to and authorize the collection and retention of my information for the purpose of the service(s) I am applying for. I understand that such information may include, but is not limited to the following:

- Identifying information (name, birth date, gender, race, social security number, residential information, phone number, family information, etc.)
- Financial information (income verification, public assistance payments and allowances, food stamp allotments, etc.)
- Medical records (HIV/AIDS diagnosis, psychological records and evaluations, vocational assessments, care coordinators recommendations/direct observation, employment status, etc.)
- Substance abuse diagnosis, treatment plans, progress in treatment, and discharge information
- Other (As specified in the space provided) _____

  _____

Additionally, please review the following bullet points:

- I understand that Martin County Human Services may contact my employer, bank, family/friends, or any other institution(s) or person(s) to verify information and confirm my eligibility for the program(s) I am applying for.
- I understand that I have the right to inspect, copy, and request all records maintained by the County relating to the provision of services to me and to receive a paper copy of this form.
- I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. If not previously revoked, this consent terminates automatically **ONE YEAR** after this form has been signed.
- I understand that my records are protected by Federal, State, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent, unless otherwise provided for in regulations.

_____ _____

Client Signature Date

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