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 Community Services Program 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

2024 Income Limits

Effective 1/22/2024

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

Monthly Income

Household/ Family Size	50%	75%	100%	125%	150%	175%	200%
1	$ 627.50	$ 941.25	$ 1,255.00	$ 1,568.75	$ 1,882.50	$ 2,196.25	$ 2,510.00
2	$ 851.67	$ 1,277.50	$ 1,703.33	$ 2,129.17	$ 2,555.00	$ 2,980.83	$ 3,406.67
3	$ 1,075.83	$ 1,613.75	$ 2,151.67	$ 2,689.58	$ 3,227.50	$ 3,765.42	$ 4,303.33
4	$ 1,300.00	$ 1,950.00	$ 2,600.00	$ 3,250.00	$ 3,900.00	$ 4,550.00	$ 5,200.00
5	$ 1,524.17	$ 2,286.25	$ 3,048.33	$ 3,810.42	$ 4,572.50	$ 5,334.58	$ 6,096.67
6	$ 1,748.33	$ 2,622.50	$ 3,496.67	$ 4,370.83	$ 5,245.00	$ 6,119.17	$ 6,993.33
7	$ 1,972.50	$ 2,958.75	$ 3,945.00	$ 4,931.25	$ 5,917.50	$ 6,903.75	$ 7,890.00
8	$ 2,196.67	$ 3,295.00	$ 4,393.33	$ 5,491.67	$ 6,590.00	$ 7,688.33	$ 8,786.67
9	$ 2,420.83	$ 3,631.25	$ 4,841.67	$ 6,052.08	$ 7,262.50	$ 8,472.92	$ 9,683.33
10	$ 2,645.00	$ 3,967.50	$ 5,290.00	$ 6,612.50	$ 7,935.00	$ 9,257.50	$ 10,580.00

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.*

Household Members	Social Security Number	Relationship	Sex	Disabled	Veteran	DOB	Age	Monthly Income	Income Source	Migrant Worker
		HOH	M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N
			M F	Y N	Y N					Y N

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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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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COMMUNITY SERVICES BLOCK GRANT
Customer Satisfaction Survey

The purpose of this survey is to provide feedback to improve services offered.
Please answer the survey in its entirety.

1. **What is your name?** *(Optional)* _____

2. **What county do you live in?**
   - ☐ St. Lucie County
   - ☐ Martin County
   - ☐ Okeechobee County

3. **Please select which services you received from our agency?**
   - ☐ Assistance applying for Benefits
   - ☐ Childcare Assistance
   - ☐ Home Health Assistance
   - ☐ Household Items
   - ☐ ID Assistance or related
   - ☐ Rental/Utility Assistance
   - ☐ Transportation Assistance
   - ☐ Education Assistance
   - ☐ Other: _____

4. **How would you rate the quality of service you have received?**
   - 4 ☐ Excellent
   - 3 ☐ Good
   - 2 ☐ Fair
   - 1 ☐ Poor

5. **Did you get the kind of service you wanted?**
   - 1 ☐ No, definitely not
   - 2 ☐ No, not really
   - 3 ☐ Yes, generally
   - 4 ☐ Yes, definitely

6. **To what extent has our program met your needs?**
   - 4 ☐ Almost all of my needs
   - 3 ☐ Most of my needs
   - 2 ☐ Only a few of my needs
   - 1 ☐ None of my needs

7. **If a friend were in need of similar help, would you recommend our program to them?**
   - 1 ☐ No, definitely not
   - 2 ☐ No, I don't think so
   - 3 ☐ Yes, I think so
   - 4 ☐ Yes, definitely

8. **How satisfied are you with the amount of help you received?**
   - 1 ☐ Quite dissatisfied
   - 2 ☐ Mildly dissatisfied
   - 3 ☐ Mostly satisfied
   - 4 ☐ Very satisfied

9. **Have the services you received helped you deal more effectively with your problems?**
   - 4 ☐ Yes, greatly
   - 3 ☐ Yes, somewhat
   - 2 ☐ No, not really
   - 1 ☐ No

10. **Over all, how satisfied are you with the services you have received?**
    - 4 ☐ Very satisfied
    - 3 ☐ Mostly satisfied
    - 2 ☐ Mildly dissatisfied
    - 1 ☐ Quite dissatisfied

11. **If you were to seek help again, would you come back to our program?**
    - 1 ☐ No, definitely
    - 2 ☐ No, I don't think so
    - 3 ☐ Yes, I think so
    - 4 ☐ Yes, definitely

Thank you for participating in our survey. Your feedback is important.