NC MedAssist
Dispensing Hope for the Uninsured

Homebound Agency: _____

- **YOU MAY SELECT A TOTAL OF 6 ITEMS**
- **NO MORE THAN 2 ITEMS PER CATEGORY**

Cough, Cold, & Flu	Allergy	Laxative/ Hemorrhoids	Pain Relief	Digestive Aids	Vitamins	Skin Treatment
Cough Syrup	Nasal Spray	Stool Softeners	Ibuprofen (Advil)	Heartburn Relief	Calcium	Anti-fungal
Daytime Cold	Allergy Relief	Enemas	Aspirin 81 mg	Fiber	Vitamin D	Anti-Itch
Cough Drops	Benadryl	Hemorrhoid Cream	Aspirin 325 mg	Anti-Diarrheal	Fish Oil	
		Laxatives	Pain Relief (Acetaminophen)	Gas Relief	Multivitamins	
					Glucosamine	
		Please write in **three (3)** additional items that may not be listed (that you may need): We will provide these items if we have them available.				

I promise that this medicine will be used for myself and not returned to a store, sold for profit, or given away.
(Yo prometo que esta medicina va a ser usada por mí y no devuelta a una tienda, vendida para lucro, o regalada).

Signature: _____ Date: _____

Mobile Free Pharmacy Homebound

NC MedAssist
Dispensing Hope for the Uninsured

Homebound Agency: _____ County: _____

Your Name (Nombre): _____

Street Address (Direccion): _____ **Apt/Unit:** _____ **City (Ciudad):** _____

Zip Code (Codigo Postal): _____ **Email (Correo Electronico):**_____ **Phone (Telefono):**_____

Gender (Sexo): FEMALE (Mujer) MALE (Hombre) **Age (Edad):** _____

Ethnicity (Etnia): Caucasian/White African American/Black American Indian/Alaska Native Asian Latino/Hispanic
Bi-Racial/Multi-Racial Native Hawaiian/Pacific Islander Other:_____

How did you hear about this event?
(Como escucho de este evento?)

____ I am a MedAssist Client
____ DSS
____ Flyer
____ Friend/Family
____ Clinic/Dr. Office/Hospital
____ Shelter
____ Radio
____ Newspaper
____ Television

Please complete the following Survey Questions (Por favor complete last siguientes preguntas):

⇒Do you currently have insurance? (Usted tiene seguro medico?):
___ Medicaid ____Medicare ___Private Insurance (Seguro Privado) ___No Insurance (No Seguro)

⇒ If you selected **No Insurance,** do you need help paying for your prescription medications?
(Si usted selecciónо **No Seguro**, necesita ayuda para pagar por sus prescripciones?)
___**Yes (Si)**, please contact me by: (Por Favor contacteme por):
___ Address (My dirección) ____ Email (Correo electrónico) ___Phone (Telefono)
___**No,** I am not interested at this time (No estoy interesado)

Notice: *Under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider's voluntary provision of health care services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer or health care provider.*

Aviso: *Bajo la ley de Carolina del Norte, un médico voluntario o proveedor de atención médica no será responsable de los daños por lesiones o muerte alegada por haber ocurrido un acto u omisión en la provisión voluntaria de servicios médicos por parte del médico o proveedor de atención médica, se establece que las lesiones o la muerte fueron causadas por una negligencia grave, una conducta desenfrenada o una mala conducta intencional por parte del voluntario o proveedor de atención médica.*