Asthma and Allergy Foundation of America - Michigan Chapter
JARED STEPHEN WILLIAMS MEDICATION ASSISTANCE FUND (JWMF)

Please email or mail this Application to:

Asthma & Allergy Foundation of America
Michigan Chapter
JWMF Request
26111 West 14 Mile, Suite LL1
Franklin, MI 48025

Email : aafamich@sbcglobal.net

PHONE: 888.444.0333

TODAY'S DATE:

Name:		**ALLERGIES:**	
Date of Birth:		**Would you allow AAFA-MI to share your asthma story with the media and other publications? No names will be used.**	**Yes or No**
Parent/Guardian if applicant under 18 years old:			
Home Phone:		**Mobile Phone:**	
Address:			
	Street	City, State Zip	
Email:		**Current Pharmacy & Phone:**	
Health Coverage Information:			
	Insurance Plan	**Policy ID # and RxGroup#**	

Need for Support

I/we confirm that we are in need of support from the JWMF medication assistance fund, due to economic hardship faced from:

☐ **Co-Pay - too high** ☐ **Household bills** ☐ **Low-Income Family**
☐ **High Deductible Plan** ☐ **Medical bills**

Are there any Allergies to medicines or food? _____

Agreement for Support

I/we agree to work with AAFA-MI and:

① **Complete education and training on good asthma management**
② **Obtain medical insurance, if needed**
③ **Develop a plan for future medication needs**
④ **See an asthma specialist at least 2 times a year**
⑤ **See the Primary Care Physician at least 2 times a year or more if needed**
⑥ **Obtain an Asthma Action Plan and follow it**
⑦ **Follow the medication plan as told by my doctor and asthma educator**
⑧ **Complete the Asthma Control Test (ACT)**

Signed: _____ Date: _____

How did you hear about our medication assistance program?

☐ **Doctor**
☐ **School**
☐ **Community Organization _____**
☐ **Facebook**
☐ **Friend**
☐ **Other _____**

For Internal use only:	Form received on:	Authorized Meds:	Amount:
Authorized		Date:	
Sent to:	MHP TCS KP		