

CCMAP Enrollment Form

The following are the steps for patients to be considered for enrollment in the CCMAP:

1. Complete the enrollment form below, including the patient's name, address, phone number, date of birth, Social Security Number, a list of medications needed and the name and address of the patient's doctor(s).
2. Mail the enrollment form to

**Cumberland County Medication Access Program
227 Fountainhead Lane
Fayetteville, North Carolina 28301**

3. Upon receipt of the information form, we will review the application and respond by phone or postcard. If you do not have a phone, please include the name and phone number of someone who can receive messages for you. We will respond as quickly as possible, but please allow at least 3-4 weeks.

Patient's Name (Last, First, Middle Initial)		Date of Birth (MM/DD/YYYY)	
Street Address		Apartment #	
City	State	Zip	
Telephone Number		Social Security Number	

1.	Name of Medication	Name and Address of Prescribing Doctor
2.	Name of Medication	Name and Address of Prescribing Doctor
3.	Name of Medication	Name and Address of Prescribing Doctor
4.	Name of Medication	Name and Address of Prescribing Doctor
5.	Name of Medication	Name and Address of Prescribing Doctor
6.	Name of Medication	Name and Address of Prescribing Doctor
7.	Name of Medication	Name and Address of Prescribing Doctor