Freemed
Prescription Assistance Checklist

301 S Boulevard, Suite #2
Idaho Falls, ID 83404
Phone: 208-528-6337, Fax: 208-528-6339
Email: freemedoffice@gmail.com

To Enroll, Please Bring the Following to Your Appointment

Identification/Citizenship Verification

Social Security Card
Drivers License
or
State ID
or
Birth Certificate
or
Resident Alien Papers/Card

Insurance Information
(Not every document may apply to you)

Current Medicaid Denial Letter
and/or
Medical Insurance Card
or
All Medicare Cards

Proof of Income/Financial Information

Current Federal Income Taxes
or
Current Social Security Benefits Letter
or
Current Veterans Benefits
or
Current Workman's Comp Benefits
or
3 most recent paystubs
or
Most recent Bank Statements (90 days worth)
or
Current Health and Welfare Benefits Letter

List of Current Medications

Bring all your current bottles/boxes with you
or
Pharmacy Print out
or
The application medication form attached

Call for an Appointment

208-528-6337
Hours: Monday - Thursday 9:00 am to 2 pm

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Applicant Information

Name:

Date

Street Address

Mailing Address (if different)

City

State:

Zip

Phone #

Birthdate:

E-mail

Social Security #

US Citizen	◯ Yes	◯ No
Legal Resident Alien	◯ Yes	◯ No
Veteran	◯ Yes	◯ No
Student	◯ Yes	◯ No
Current Federal Income Taxes	◯ Yes	◯ No
Social Security Disability	◯ Yes	◯ No
Copy of Medicaid Denial Letter	◯ Yes	◯ No

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Gender ○ Male ○ Female

Employment Status ☐ Part- Time Employed ☐ Full-Time Employed ☐ Unemployed ☐ Self Employed ☐ Retired ☐ Other

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

# of people in the Household _____ Monthly Income _____

Diagnosis _____

Drug Allergies _____

Client Physician Information

Dr. Name _____

Dr. Address _____

City _____ State _____ Zip _____

Phone # _____

Fax # _____

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Name:

Date:

Medications

RIGHTS AND RESPONSIBILITIES OF CLIENTS WITH THE PATIENT ASSISTANCE PROGRAM

Upon acceptance into the Freemed Patient Assistance Progran, you have the following rights and Responsibilities.

YOU HAVE THE RIGHT TO:	YOUR RESPONSIBILITIES ARE:
To receive services without regard to race, gender, national origin, religion, language, sexual orientation, or political affiliation.	To sign "Release of Information" forms to agencies necessary to provide appropriate services for you
To have all program policies and procedures explained to you.	To comply with all reporting requirements including giving notice **within 7 days** of any change in address, phone number, income, and insurance status.
To participate actively in the Freemed Patient Assistance Program.	To provide documentation when requested, **within 7 days** to your patient advocate to support the services provided to you.
To be treated fairly, with dignity, courtesy and respect.	To treat Program staff fairly, with dignity, courtesy and respect.
To be notified in writing within 10 days of any action that affects your receipt patient assistance services.	To notify FREEMED when circumstances are affecting your ability to comply with program requirements. **To respond within 7 days of any contact from us.**

I have read the Rights and Responsibilities for participation in the FREEMED Patient Assistance program listed above. My signature on this form indicated that I have been informed of these Rights and Responsibilities and agree to abide by them as a client in the Program. I understand that failure to respect the rights andresponsibilities above may result in my being discharged From the FREEMED Patient Assistance Program.

_____ _____

Signature of Client Date

_____ _____

Signature of Patient Advocate Date

A COPY WAS GIVEN TO CLIENT