

Health Med Assist, Inc.

CONNECTING PRESCRIPTION USERS WITH FREE DRUG PROGRAMS

Pharmaceutical companies gave away more than \$1.5 billion in free prescriptions to people meeting their guidelines last year, yet only a small fraction of those eligible ever apply. As a general rule, you will qualify if –

- You have no prescription coverage or have exceeded your policy limits, AND
- You are single and earn less than \$1,500 per month, or married and as a couple earn less than \$2,000 per month.

How Does the Program Work?

Simply fill out the attached Health Med Assist application form and mail it back to us at the address below, along with the required income documentation and application fee. Our computers complete the pharmaceutical company forms and forward them to your doctor to be signed and dropped in pre-stamped mailers to the drug companies for review.

Upon approval, your free medications (typically a 90-day supply) are generally sent to your physician, whose staff notifies you that the drugs are available for pick up. We follow up when it is time to renew your applications. Virtually all classes of prescriptions are available except generic drugs and controlled substances. If you qualify, your drugs arrive approximately 6-8 weeks after you apply.

Who is Health Med Assist?

Health Med Assist is a patient advocate organization founded in 1999 by a Doctor of Pharmacy with 15 years of experience working with pharmaceutical assistance programs. Our transactional computer system eliminates much of the confusion that has prevented most eligible people from applying for Patient Assistance Programs.

What Does This Service Cost?

Health Med Assist charges a one-time application fee of \$25, regardless of the number of drugs you apply for, plus a file maintenance fee of \$10 per prescription per month. If both a husband and wife apply, two application forms (and two \$25 checks) are required. Last year our average client saved \$250 per month in prescription costs – over \$3,000 per year!

Do You Have Friends or Loved Ones Who Need Help Meeting Prescription Costs?

We'd be delighted to explain how our program operates. If they would like to participate, we'll mail out a free application form. Have your friend call us at (801) 277-9769, or toll free at (877) 277-9769.

Administered by Health Med Assist

4659 South 2300 East, Suite 205, Salt Lake City, Utah 84117
Tel (801) 277-9769 / Fax (801) 274-3229 / Toll Free (877) 277-9769
hma@healthgroupnet.com / www.healthmedassist.com

Application Form

Pharmaceutical companies require the following information to process your application for free drugs. Please call us if you need any assistance – (801) 277-9769 in Utah, or toll free (877) 277-9769.

Patient Name		Telephone	
Date of Birth		Social Security number	
Street Address		Email address / Fax (if any)	
City, State, Zip		Alternate Contact Name	
Total Monthly Income		Alternate Contact Telephone	
Primary Insurance Co. Name		Is Alternate the Main Contact?	Yes ___ No ___
Secondary Ins. (if any)		Any Prescription Coverage?	Yes ___ No ___
Male ___ Female ___	Married ___ Single ___	Divorced ___ Widowed ___	File Tax Return? Yes ___ No ___
Weight _____ Height _____	A Veteran? Yes ___ No ___	Legally disabled? Yes ___ No ___	Childproof Caps? Yes ___ No ___
Referred by	NeedyMeds.com	___ People in Your Household	Applied for Medicaid Yes ___ No ___

Please supply the following information about the doctors who prescribe medication for you.

Prescribing Doctor Name (1)		Prescribing Doctor Name (2)	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Clinic Name & Specialty		Clinic Name & Specialty	
Telephone		Telephone	

Please complete the table below - the prescription name, the number of 'mg,' how you were directed to take the medication ("one or two tablets every four hours as needed") and the prescribing doctor.

Medication Name	# mg	Directions	Doctor 1 or 2
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

If you need more space for any of the information provided above, please use the other side of this sheet.

Please list your medical conditions: _____

Please list any medications to which you are allergic: _____

Income & Expense Information

Patient Name: _____

Please fill out the following information so that we can write supplemental letters to the pharmaceutical companies describing your expenses and your income if the need arises.

Monthly Household Expenses

Mortgage or rent	\$
Cable TV	\$
Loan payments	\$
Credit card payments	\$
Utilities & phone	\$
Car & home insurance	\$
Medical insurance	\$
Prescriptions (household)	\$
Groceries	\$
Gasoline	\$
Newspaper & magazines	\$
Life insurance	\$
Property Tax	\$
Other	\$
Total Monthly Expenses	\$

Monthly Gross Household Income

Social Security	\$
Pension	\$
Investment income	\$
Wages	\$
Alimony & child support	\$
Disability	\$
Unemployment	\$
Other	\$
Total Income	\$
Quarterly Income (if any)	\$

Liquid Assets of Household

Savings account balance	\$
CD value	\$
Money market fund value	\$
Stocks & Bonds	\$
Other	\$
Total Liquid Assets	\$

Please Attach Proof of Income

Please attach copies of documents needed to verify each of your sources of income to the satisfaction of the drug companies to which the applications are submitted.

► **Social Security Benefits Statement.** The preferred document is a Social Security Benefits Statement for the current year. If you cannot locate this statement, just call the Social Security Administration toll free at 1-800-772-1213, then select options 1, 4, then 2 during the lengthy recording. The Statement is normally mailed to you within 2 weeks. A new statement will be needed every year.

► **Pension Confirmation Letter.** If you receive a pension, drug companies require a letter on the pension company stationery stating the amount of the payment, and that the amount does not change during the year. This letter can be obtained by calling the company paying the pension. A new letter will be needed every year.

► **Paycheck Stubs or Bank Statements.** If you work, please attach copies of the stubs from your last month's paycheck(s). A new set of stubs will be needed periodically. If you receive Social Security or a pension, but cannot obtain a Social Security Benefits Statement or Pension Confirmation Letter, submit your *last month's* Bank Statement. A new Bank Statement will be needed periodically.

Please Attach Completed IRS Form 4506

If you do NOT file a tax return, please complete the circled items on the attached Form 4506. But if you DO file a tax return, please submit pages 1-2 of last year's return.

Please Attach Your Check for \$25

Health Med Assist, Inc. charges a one-time application fee of \$25, which will be refunded to you if you don't appear to be qualified for any free drugs. This covers the cost of preparing all your application forms. A monthly paperwork processing fee of \$10 per prescription is also required for keeping your information current to ensure a reliable supply of prescriptions. You will be billed each month.

Authorization for Release of Medical Information

Patient Name:		Birth Date:	
Street Address:		Phone:	
City, State, Zip:		SSN:	
Health Care Providers:		Phone:	

By my signature below, I hereby authorize the above-named health care providers to release the following information from my medical file to Health Med Assist, Inc., 4659 South 2300 East, Suite 203, SLC, UT 84117: all prescription information, my diagnosis and problem list, results of my last physical and last three progress notes. This authorization also pertains to testing for AIDS, drugs, alcohol, and mental health records. I acknowledge that data to be released may include material that is protected by Federal Regulations 42 CFR Part 2 and 45 CFR Parts 160 and 164.

Other Agreements

In consideration for the services provided by Health Med Assist, Inc. ("the Company"), I hereby agree to pay a one-time application fee of \$25 for the purpose of determining my eligibility for financial assistance on my prescribed medications, and a monthly paperwork processing fee of \$10 per prescription. If I fail to pay when due, I agree to pay all expenses of collection incurred by the Company or its assignee. I understand that a few pharmaceutical companies may charge an additional "stocking fee" of \$5-10 to be paid if I pick up their drugs at my local pharmacy.

I attest that I do not currently have any prescription insurance benefits either because I am uninsured or because I have exceeded my coverage limits at the time of this application. For this purpose, a prescription discount card is not considered prescription coverage. I understand that if I fail to notify the Company of medication changes prescribed by my physician(s) I may receive medications for which no current prescription exists and which may be potentially hazardous to my health.

I certify that the information I have provided to the Company, including without limitation the proof of household income I have supplied, is true and complete. I authorize any party to whom I have given documentary proof of my income and expenses, including without limitation a Social Security Benefits Statement, to provide copies thereof to the Company solely for the purpose of applying to pharmaceutical companies for grant drugs.

I understand that the Company acts only as a processing assistant to help me apply for free drugs offered by pharmaceutical companies; it does not manufacture drugs, prescribe drugs, recommend medication, or evaluate prescriptions. Accordingly, I waive any and all past and future claims I may have against the Company arising out of my participation in its drug program, and agree to indemnify the Company, its employees, and representatives, against any claims made by persons arising out of my participation. I assume all responsibility for notifying the Company of changes made to medication regimens.

I appoint the Company my attorney-in-fact for the limited purposes of signing in my behalf any communications or agreements with pharmaceutical companies, or other entities engaged by them to administer patient assistance programs, to which I may apply, and disclosing to such entities any of the medical information contained in the attached application form or proof of income documents submitted by me.

Date

Signature of Patient

Request for Transcript of Tax Return

Department of the Treasury
Internal Revenue Service

- ▶ Do not sign this form unless all applicable parts have been completed.
Read the instructions on page 2.
- ▶ Request may be rejected if the form is incomplete, illegible, or any required part was blank at the time of signature.

TIP: Use new Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can also call 1-800-829-1040 to order a transcript. If you need a copy of your return, use **Form 4506**, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
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2a If a joint return, enter spouse's name shown on tax return	2b Second social security number if joint tax return : : : :
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3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Address, (including apt., room, or suite no.), city, state, and ZIP code shown on the last return filed if different from line 3

5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.

CAUTION: Lines 6 and 7 must be completed if the third party requires you to complete Form 4506-T. Do not sign Form 4506-T if the third party requests that you sign Form 4506-T and lines 6 and 7 are blank.

6 Product requested. Most requests will be processed within 10 business days. If the product requested relates to information from a return filed more than 4 years ago, it may take up to 30 days. Enter the return number here and check the box below. ▶ _____

- a Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. Transcripts are generally available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years
- b Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns
- c Record of Account**, which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years
- d Verification of Nonfiling**, which is proof from the IRS that you did not file a return for the year
- e Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2003, filed in 2004, will not be available from the IRS until 2005. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213

CAUTION: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T.

____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer.

Sign Here	_____ Signature (see instructions)	_____ Date	Telephone number of taxpayer on line 1a or 2a () _____
	_____ Title (if line 1a above is a corporation, partnership, estate, or trust)		
	_____ Spouse's signature	_____ Date	