Bobby Goldsmith Foundation Client Medication List

bobby goldsmith foundation
practical emotional financial support

Please note-Submitting this form does not guarantee eligibility for co-payment or financial assistance.

To seek financial assistance for your medications, vitamins, supplementary and complimentary therapies your prescribing doctor must complete this page.
Only medication and therapies prescribed by your doctor will be considered for financial assistance.
Annual caps apply. Regular reviews of assistance agreements will be conducted.

Client Name _____ **DOB**_____ _____

HIV Medication

Antiretroviral medication	**PBS**
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No
	☐ Yes ☐ No

Comorbid Medications

Condition	**Medication**	**PBS**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Vitamins & Supplements

Name	**Dose**

Complementary Therapies

Name	**Frequency**

Prescribing Doctor _____

Signature _____

Date _____

Surgery / Clinic stamp

Medications will only be approved for subsidy following proof of eligibility via the assessment intake process. BGF provides approved clients with access to antiretroviral medication on account at several major hospital pharmacies. BGF also provides approved clients with financial assistance to obtain HIV related Non PBS listed medication and comorbid medication. Total invoice amount needs to be $15 or more.

I, _____ give consent for my medication details to be given to BGF.

Client Signature _____ Date _____