

2008-2009 "LIFELINE" Application – Page 1

The LIFELINE program is to help with health insurance premiums, COBRA payments, out-of-pockets or medical expenses, and other costs related to treating bleeding disorders.

LIFELINE is offered through the Utah Hemophilia Foundation, in conjunction with the Utah Department of Health and the Utah State Legislature – U.C.A 26-47.

Eligibility Requirements:

- 1) Must be a Utah resident, living in the state for the past 12 months or longer
- 2) Must verify type(s) of bleeding disorder(s) in the household
- 3) Must verify that medical expenses (COBRA payments, health insurance premiums, etc.) are greater than 7.5% of your adjusted gross income*

* To determine income eligibility, please fill out the following calculation:

- (1) \$ _____ Household's Annual Adjusted Gross Income (AGI)
- (2) \$ _____ x 7.5% (multiply line 1 by .075)
- (3) \$ _____ Household's Annual total amount PAID BY YOU for health insurance, COBRA, out-of-pocket expenses, and other medical expenses.

**If line 3 is greater than line 2, fill out and submit a LIFELINE application.
If line 2 is greater than line 3, you are ineligible for LIFELINE at this time.**

Instructions: Please completely fill out the attached application and then mail or fax it, and all required documentation, to the Utah Hemophilia Foundation, 772 East 3300 South, Suite 210 or fax 801-746-2488. **PLEASE CALL THE UHF IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE WITH THIS APPLICATION (801) 484-0325 or toll free 877-463-6893.**

Please submit the following REQUIRED documents with this application:

(Not submitting this information could result in a delay with the processing of your application.)

- ✓ Copy (front and back) of your current health insurance card
- ✓ A letter from the HTC, a hematologist, or primary care physician verifying bleeding disorder(s) diagnosis (see attached form)
- ✓ Proof of Health Insurance payments and/or Payroll Deductions for past 2 months
- ✓ Proof of your COBRA payments for past 2 months (If applicable)
- ✓ Proof of your Medical / Out-of-Pocket expenses to verify 7.5% out-of-pocket requirement
- ✓ Check stubs for past 2 months for each employed adult in the household
- ✓ Copy of first 2 pages of latest signed IRS tax return

UHF office use only

Date application received: _____

2008-2009 “LIFELINE” Application – page 2

Date: _____

Your First Name: _____ Last Name: _____

Current Home Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: (_____) _____ Evening Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Mailing address if different from above: _____

City: _____ State: _____ Zip: _____

How long have you lived at the address above? _____

If less than one year, please provide your previous addresses for the past 12 months:

Previous Address: _____

City: _____ State: _____ Zip: _____

Previous Address: _____

City: _____ State: _____ Zip: _____

Your Date of Birth: ___/___/___ Driver’s License #: _____ State: _____

List EVERY person with a bleeding disorder currently living in your household:

Relation to You	First and Last Name	Date of Birth	Name of Bleeding Disorder (B.D.)	B.D. Type	Ethnicity *

* Required by State - use these categories to identify the ethnicity of each person with a bleeding disorder:

- 1 - Asian 2 - African American or Black 3 - American Indian or Alaska Native
 4 - Caucasian or White 5 - Hispanic or Latino 6 - Native Hawaiian or Other Pacific Islander

2008-2009 "LIFELINE" Application – page 3

Please indicate what you want LIFELINE to help with – you can check more than one:

€ Health Insurance Premiums

€ COBRA Payments

€ Medical / Out-of-Pocket Expenses (hospital, doctor, pharmacy, etc.)

€ Other: _____

INSURANCE INFORMATION

Does your household currently have health insurance? YES or NO*
**(If no, skip to next section)*

Are those with bleeding disorders covered under this policy? YES or NO

If yes, what health insurance company covers family members with bleeding disorders?
(including Medicaid & Medicare) _____

Please fill out the following section with information from your health insurance card:

Policy or Identification Number: _____ Effective Date: _____

Medical Claims Address: _____ City: _____

State: _____ Zip: _____ Claims Phone Number: (____) _____

Cost of health insurance premiums: _____ Monthly or Annually

How much of the insurance premium do you pay? _____ Monthly or Annually

Are your premiums paid via payroll deductions? YES or NO

Would you consider your family under-insured? YES or NO

If yes, please explain:

EMPLOYMENT INFORMATION

Are you currently employed? YES or NO **(If no, skip to next section)*

Name of your employer: _____

Employer's address: _____

City: _____ State: _____ Zip: _____

Length of time with current employer: _____

Name of Spouse's Employer: _____

Spouse's Employer's Address: _____

City: _____ State: _____ Zip: _____

Spouse's Length of time with current employer: _____

2008-2009 “LIFELINE” Application – page 4

INCOME INFORMATION

List adjusted gross income for you and your spouse: \$ _____

List number of dependents you will claim on your federal tax return: _____

List other household members currently living with you: _____

Check current marital status: Single Married Separated
 (As indicated on your tax return) Divorced Widowed Head-of-Household

Please explain all extenuating circumstances (financial, family) you would like considered: _____

List additional financial assistance/income you've received from other sources in the past 12 months:

Who	When	How Much \$
_____	_____	_____
_____	_____	_____
_____	_____	_____

DETAIL OF MEDICAL EXPENSES/REQUEST FOR REIMBURSEMENT

Please fill in the following information so we might have a complete understanding of your reimbursement request.

<i>Date of bill or premium notice</i>	<i>Type of Expense (premium, COBRA, out of pocket medical, etc.)</i>	<i>TOTAL Amount Owing</i>	<i>Amount Paid by YOU</i>	<i>Amount Requested for Reimbursement through LIFELINE</i>	<i>Have you enclosed proof of payment with application? (Yes or No)</i>

A requirement of the LIFELINE program is to submit a letter from your doctor to verify the bleeding disorder in your household with your application.

Please fill out this form and then hand-deliver, fax or mail it to the Mountain States Hemophilia Treatment Center/HTC (see address below), or your hematologist or primary care physician so that they can release medical information about you and/or your family to the Utah Hemophilia Foundation.

I, _____, authorize
(First and last name)

_____, to release
(Name of physician or medical facility)

medical information to the Utah Hemophilia Foundation (UHF). At your earliest convenience, please fax or mail a letter, on letterhead, to the UHF outlining the bleeding disorder(s) that affect my family.

Thank you!

Your signature

Your home phone number

Date

HTC mailing address:

Mountain States HTC
100 North Medical Dr.
Salt Lake City, UT 84113

HTC fax number:

(801) 662-4838

MEDICAL FACILITY: After receiving this form, please send letter to verify bleeding disorder for this patient to:

Utah Hemophilia Foundation
772 East 3300 South, Suite 210
Salt Lake City, UT 84106

Or fax verification to:

ATTN: Utah Hemophilia Foundation
(801) 746-2488