

Lifeline Program Guidelines

The Lifeline Program is a fund through which individuals with bleeding disorders can receive financial help with high insurance premiums, COBRA payments, and out-of-pocket medical expenses associated with the diagnosis and treatment of bleeding disorders. Monies for the Lifeline Program are appropriated from July to June. The Utah State Legislature originally and currently appropriates \$250,000 per year for this program. Participation in the program has grown considerably since its inception.

As participation in the program grows, the Lifeline Review Committee has established a series of guidelines to distribute these state funds in the most effective and appropriate way. The goal of the program is to assist as many participants as possible and to give help to those who need it most. Therefore, the following guidelines have been developed. The Committee reserves the right to judge applicants on a case by case basis and to deviate from these guidelines for extenuating circumstances.

- The full Lifeline Application needs to be completed once a year and must include, among other things, the applicant's most recent tax return and proof of paid out of pocket medical expenses prior to consideration. Additional expenses in the same fiscal year can be submitted on the Lifeline Subsequent Application. Verification of medical expenses must be in the form of cancelled checks, receipts, credit card statements, etc. HSA statements will require back up documentation in the form of receipts, etc. to be considered. Expenses taken in the form trade rather than actual out of pocket will not be considered as a medical expense qualifying for Lifeline consideration.
- Committee members will hold each other accountable and not let personal bias of any applicant and/or family member weigh into the decisions made by the Committee.
- The Committee will evaluate individual resources and base reimbursement on those criteria.
- Each open Lifeline case will be reviewed every 6 months.
- Consideration for all outstanding medical expenses will be for the past fiscal year. Applicants may use all of the previous year's expenses to determine eligibility, however, the previous six months will only be considered for reimbursement. Additionally, each medical expense submitted is subject to review.
- As appropriate, insurance premiums and COBRA payments may be considered for six months retroactively and six months in advance, if funds are available. As circumstances dictate and as the money is available, other considerations will be considered.

- Surgery assistance will be decided only after the surgery is complete and all bills and paperwork, including the Lifeline application has been submitted to the Lifeline Committee. Applicants may complete the application prior to surgery, for an indication of their eligibility for assistance.
- All other financial resources should be exhausted before applicants seek assistance from the Lifeline program. As of January 1, 2008, the Lifeline Committee will require that all applicants exhaust all other avenues for financial assistance, including financial waivers from home care companies, before being considered for Lifeline assistance. An exception to this policy would be PSI, Inc. (because funds from PSI may not be available.) The same level of assistance cannot be guaranteed for applicants who re-apply to the Lifeline program.
- Applicants need to indicate where and to whom reimbursement checks from the Lifeline Program need to be sent.
- The Committee will require a Patient Advocate release form, for those patients who wish to involve their home health care representative in the Lifeline application process. This signed form, similar to the medical release form, should provide consent for the Patient Advocate to share and receive information on their behalf pertinent to their Lifeline application.
- Lifeline will not pay on accounts that have gone to collections. Applicants need to be proactive in applying for financial help before collection and finance charges have been incurred.
- Testing costs may be eligible for diagnosis or to validate a diagnosis. However, protracted diagnostics will not be considered.
- Applicants not on standard treatment must provide a letter from their physician as to why they are deviating from standard treatment practices.
- Applicants who have been terminated from their employment may automatically be eligible to receive Lifeline assistance with insurance premiums or COBRA premiums if there is no other working adult in the household. Applications received under this circumstance will need to be reviewed on an individual basis.

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