

# 2011-2012 “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\*
- 4) Must be a United States citizen or a permanent resident alien or hold a valid visa

\* 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) \*only necessary for first time applicants
- ✓ Proof of Health Insurance payments and/or Payroll Deductions for past 2 months
- ✓ Proof of your COBRA payments for past 2 months (If applicable)
- ✓ Copies of receipts/checks, etc. of paid medical expenses for the previous 12 months equal to or exceeding 7.5% of your AGI
- ✓ Check stubs for past 2 months for each employed adult in the household
- ✓ Copy of first 2 pages of latest signed IRS tax return
- ✓ Include a copy of a valid form of identification (current drivers' license, passport, etc.)

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<b>UHF OFFICE USE ONLY</b>	Date Received in UHF Office: _____
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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: \_\_\_\_\_

Are you a citizen of the United States? YES or NO  
*(If “Yes”, include a copy of a valid form of identification: current drivers’ license, passport, etc.)*

Are you a permanent resident alien or hold a valid visa? YES or NO  
*(If “Yes”, include a copy of passport or visa with alien identification number)*

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

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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

Name of your employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Length of time with current employer: \_\_\_\_\_

### SPOUSE'S EMPLOYMENT INFORMATION

Is your spouse currently employed? YES or NO

Name of Spouse's Employer: \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_

Spouse's Length of time with current employer: \_\_\_\_\_

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### 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 (please also include past Lifeline assistance):

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 (use the back of this form if necessary).

Date of bill or premium notice	Type of Expense (premium, COBRA, out of pocket medical, etc.)	TOTAL Amount You Owe to Facility	Total Amount Paid by YOU to the facility owing.	Amount Requested for Reimbursement through LIFELINE	Have you enclosed copy of your check or credit card statement with application? (Yes or No)

I certify that the information I have submitted is true and correct to the best of my knowledge. If any of the information I have submitted proves to be inaccurate or false I understand that Lifeline may re-evaluate my financial status and take action to collect funds that have been awarded to me. Additionally, if needed, staff members from the HTC may verify the relevance of the above services to the treatment and management of my bleeding disorder.

Applicant Signature \_\_\_\_\_

Date \_\_\_\_\_

UHF

A requirement of the LIFELINE program is to submit a letter from your doctor to verify your bleeding disorder with your application. Please fill out this form and then **hand-deliver, fax or mail it to the Intermountain Hemophilia and Thrombosis Center (see address below), your hematologist or primary care physician** so that they can release medical information about you and/or your family to the Utah Hemophilia Foundation. **Do not send this with your application. Please give to your primary care physician to authorize the release of this information.** (*\*If you have previously applied to Lifeline this is not necessary.*)

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

**IHTC mailing address:**

Intermtn Hemophilia & Thrombosis Center  
100 North Mario Caprechi Drive  
Salt Lake City, UT 84113

**IHTC fax number:**

(801) 662-4838

**If a medical facility (the IHTC or other) is receiving this form, please have them fill out letter verifying bleeding disorder and mail to:**

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

**Or fax letter to:**

801-746-2488