Assistance Fund
4700 Millenia Blvd., Suite 410
Orlando, Florida 32839

To whom it may concern,

Thank you for your interest in The Assistance Fund. The Assistance Fund was established to assist patients with paying for their medication copays, health insurance coverage premiums and/or basic medical incidental expenses. If the program is open and funds are available upon receipt of the completed enrollment application, we will accept and process for final eligibility.

To be considered for participation you **must**:

- Return a completed Enrollment Application via mail or fax.
- Be U.S. citizen or permanent resident.
- Be diagnosed with the specific disease
- Be prescribed one of the approved disease state related medications
- Have prescription drug coverage or be in the process of securing health insurance coverage for the approved disease state and related medications
- Be within the income level and household size eligibility criteria

How do you apply for assistance?

Please follow the steps listed below.

1. Complete the attached Enrollment Application in full including a signature on pages 3 and 4.
2. Mail or Fax the completed and signed application pages 1, 2, 3 and 4 to:
    - Address: The Assistance Fund – 4700 Millenia Blvd., Suite 410 – Orlando, Florida 32839
    - Fax: (866) 254-9411

We will accept and process completed enrollment applications only. Once we receive the completed enrollment application, final evaluation and program eligibility will be determined.

Please note: Incomplete or incorrect enrollment applications will delay the process and completing the application does not guarantee acceptance in the program(s).

If you have any questions or concerns, please contact a Patient Advocate Monday through Friday from 9:00AM – 6:00PM (Eastern Standard Time) excluding holidays by phone at (855)-845-3663.

Sincerely,

The Assistance Fund Program Team

The Assistance Fund 2016 Enrollment Application

Patient Information – Please Complete in Full

Patient Information – Complete in Full

Patient Legal Last Name:	Legal First Name:	Marital Status: ☐ Married ☐ Single	TAFID: TBD
Primary Phone: ☐ Home ☐ Cell ( )	Secondary Phone: ☐ Home ☐ Other ( )	Social Security Number: __ __ __ – __ __ - __ __ __ __	
Mailing Address or P.O Box:	E-mail Address:	TAF may contact me via text message or Email regarding my assistance. ☐ Yes ☐ No	
City:	State:	Zip Code:	Are you a U.S Veteran: ☐ Yes ☐ No
Gender: ☐Male ☐Female	Date of Birth (MM/DD/YYYY) / /	Diagnosis: **Select the Program(s) below:**	Prescribed Medication:

☐ **A**nkylosing Spondylitis Copay
☐ **B**reast Cancer Copay
☐ **C**lostridium Difficile Associated Diarrhea Copay
☐ **C**rohn's Copay
☐ **C**ystic Fibrosis Copay & Administration
☐ **D**igestive Motility & Malabsorption Disorders Financial
☐ **H**epatitis C Copay
☐ **H**ereditary Angioedema Financial Assistance
☐ **I**nfantile Spasms Copay
☐ **I**ron Deficiency Anemia Copay
☐ **J**uvenile Arthritis Copay
☐ **M**elanoma Copay
☐ **M**ultiple Sclerosis Copay
☐ **M**ultiple Sclerosis Health Premium, Travel & Medical
☐ **M**yositis Copay
☐ **N**ephrotic Syndrome Copay
☐ **N**euroendocrine Tumors Copay
☐ **N**on-Small Cell Lung Cancer Copay
☐ **P**arathyroid Disease Financial Assistance
☐ **P**arkinson's Copay
☐ **P**rimary Biliary Cholangitis (Cirrhosis) Financial
☐ **P**soriasis Copay
☐ **P**soriatic Arthritis Copay
☐ **R**enal Cell Carcinoma Copay
☐ **R**heumatoid Arthritis Copay
☐ **S**arcoidosis Copay
☐ **S**hort Bowel Syndrome Financial
☐ **S**kin & Skin Structure Infections Copay
☐ **S**ystemic Lupus Erythematosus Copay
☐ **U**lcerative Colitis Copay
☐ **U**veitis Copay
☐ **OTHER** _____

Race/Ethic Origin: ☐ Native American ☐ Hispanic or Latino ☐ White ☐ Asian ☐ Black or African American ☐ Hawaiian ☐ Other _____	Are you a U.S. citizen or permanent resident? ☐ Yes ☐ No

Alternate Contact First and Last Name:	Relationship to Patient:	Contact Phone: ☐ Home ☐ Cell ( )

Insurance & Pharmacy Information

Do you have health insurance? ☐ Yes ☐ No (**If Yes** - Check all that apply):
☐ Not Applicable ☐ Medicare ☐ Medicaid ☐ State Medical Aid ☐ Commercial Coverage ☐ Health Exchange

Does your Health Insurance Cover the Prescribed Medication listed above? ☐ Yes ☐ No
Are you in the process of securing Health Insurance Coverage for the Prescribed Medication? ☐ Yes ☐ No

Name of Insurance:		Cardholder First and Last Name:	Relationship:
Member ID #:	Group #:	Phone: ( )	Secondary Phone: ( )

Pharmacy Name dispensing the medication **or Office / Location Name** where the medication will be administered:

Pharmacy Phone Number: ( )	**Office / Location** Phone Number: ( )
Pharmacy Fax Number: ( )	**Office / Location** Fax Number: ( )

Income

Household Size: # of people who contribute to or are dependent on your current annual household income including yourself

(Check appropriate box) 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Other ____ (list number of people)

Current Annual Household Income based on Above Household Size: **$**_____

2016 Program Enrollment Agreements

Compliance: I understand that, if I am accepted into programs offered by The Assistance Fund, that financial assistance is being provided to help me afford my medications, my health insurance premiums, other basic needs and/or incidental medical-related expenses. Therefore, I agree to take my medications for which I receive financial assistance from The Assistance Fund and/or agree to timely pay my health insurance premiums, the costs of my basic needs and/or my incidental medical-related expenses for which I receive financial assistance from The Assistance Fund. In the event that I do not comply with my medication regimen or pay for my health insurance premiums, the costs of my basic needs or my incidental medical-related expenses as agreed, then I will be removed from participation in the program(s) offered by The Assistance Fund.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that The Assistance Fund is required to screen all applicants for compliance with its designated financial eligibility criteria prior to enrollment in its programs or within a reasonable time thereafter. I understand that The Assistance Fund intends to contract with a third-party vendor to verify the Income Information and Household Size I provide in my enrollment application. I further understand that, at any time during my enrollment in a program at The Assistance Fund, I may be contacted to request documentation of the Income Information and Household Size that I provided in my enrollment application for participation in such program(s). I understand that if The Assistance Fund (or its third-party vendor) requests evidence to support my Income Information or Household Size, that I must respond to The Assistance Fund (or its third-party vendor) and submit the requested information within the designated timeframe provided. If I fail to submit the requested documentation within the designated timeframe, I may be removed from the program.

I understand that I am free at any time to switch healthcare providers, practitioners, pharmacies, insurers or other healthcare suppliers without affecting my continued eligibility for assistance. I understand my application for assistance does not guarantee funding is or will be available. I understand that if I am approved for participation in a program, such financial assistance is provided for up to twelve months. Thereafter I must reapply for assistance each twelve months. Assistance in any year is always subject to the availability of funds and there is no guarantee such funds will be available.

Provision of Assistance: I acknowledge that The Assistance Fund provides financial assistance to individuals who qualify for participation pursuant to the rules established by The Assistance Fund. I further agree that, if approved for financial assistance, my participation requires that I meet the program rules throughout the period of time that I receive assistance from The Assistance Fund.

Change in Insurance, Household Income/Household Size, or Other Information Provided in this Application: I agree that, at any time that I am receiving assistance from The Assistance Fund, if my insurance benefit changes, if I am no longer in need of assistance, in need of less assistance, or my Income Information or Household Size changes, I will immediately notify The Assistance Fund and provide such change. Changes may impact my participation in The Assistance Fund program(s), including a reduction in the amount of assistance provided or a termination of assistance entirely. All provisions of

assistance are based upon the program rules established by The Assistance Fund and not all applicants are eligible for participation.

Furthermore, if I begin receiving government benefits and any portion of the benefits are for retroactive financial assistance, I am responsible for reimbursing The Assistance Fund for the same amount of retroactive assistance that I received under this program.

Waiver and Release of Liability: I understand that, if I am enrolled in The Assistance Fund's health insurance premium assistance program, at the option of The Assistance Fund, funds may be paid directly to my insurance provider or to me as reimbursement for my payment to my insurance provider. I understand that the amount of assistance that I receive may only partially cover my insurance premiums. If the assistance only partially covers my insurance premiums, I understand that I have the responsibility to pay the balance of such premiums in order to fulfill my financial obligation with my insurer. I understand that a policy of insurance that is underwritten to cover me is my responsibility and that I retain the responsibility to ensure that the related insurance premiums are paid in accordance with the insurance contract terms and conditions. I hereby release The Assistance Fund from liability and forever waive my right to make a claim against The Assistance Fund for the cancellation of, non-renewal of, or denial of insurance (or any such application of insurance). I agree that it is my obligation to contact The Assistance Fund if I receive a notice of cancellation, non-renewal, or denial of insurance as such information may impact my ability to receive assistance from The Assistance Fund for such program(s).

Signature of Patient or Patient's Representative (*if Representative has Legal/Medical Proxy or POA)*	Date
Print Name of Patient or Patient's Representative *(if Representative has Legal/Medical Proxy or POA)*	Relationship to Patient (Legal authority to execute this authorization)

Patient Authorization for the Release of Protected Health Information:

I authorize my treating healthcare providers and insurance benefit providers (including my insurance benefit providers' administrator, if any) to disclose my health records and any individually identifiable health information ("Protected Health Information") contained therein to The Assistance Fund, Inc., a non-profit organization. The purposes of this disclosure are: (i) to allow The Assistance Fund to process my application for program participation and, if I am determined eligible and funds are available, to enroll me in a program(s), (ii) to investigate my eligibility for assistance with other assistance programs, where applicable, (iii) to analyze and evaluate The Assistance Fund's programs to determine trends in insurance reimbursement, patient therapy compliance and other statistics related to The Assistance Fund's programs. De-identified data may be used as permitted by law.

I understand that, once my Protected Health Information is released pursuant to this authorization that it may be subject to re-disclosure and may no longer be protected by the HIPAA Privacy Rule. I may withdraw this authorization at any time by mailing or faxing a letter of revocation to The Assistance Fund at: The Assistance Fund, Inc., 4700 Millenia Boulevard, Suite 410, Orlando, FL 32839. I acknowledge that such revocation will not have an effect on any actions taken by my treating healthcare providers, insurance benefit providers and insurance benefit providers' administrator, if any, prior to The Assistance Fund's receipt of my revocation of this authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through The Assistance Fund's programs. This authorization expires one year from the date of execution.

Signature of Patient or Patient's Representative (*if Representative has Legal/Medical Proxy or POA)*	Date
Print Name of Patient or Patient's Representative *(if Representative has Legal/Medical Proxy or POA)*	Relationship to Patient (Legal authority to execute this authorization)