2011 Patient Application

Patient Name: ____________________ SSN: _________________________

During the application review period, we will make a determination of the amount of funding you will receive based on our Program Guidelines. If you are approved into one of our programs, we will provide you with financial assistance based on the remaining Calendar Year and subject to our funding limitations. We will then contact you and/or your pharmacy with our final determination.

Further, if you are approved, we will provide you with free access to our therapy management portal found at portal.cdfund.org. You will be provided a Patient ID to be used as your User Login. We encourage you to use the site at least once per month and answer the questions. The site will provide you with value-added benefits including your ability to track your health, an interactive calendar to manage your therapy, information about your medical condition, as well as important information about new studies or new therapies when they become available.

Eligibility information

You **MUST** provide **ONE** of the following to document household income:

- ☐ Your most recent **tax return**
- ☐ Letter from **Social Security** stating income for each member in your household.
- ☐ Most recent **W-2s or 1099s** for your household
- ☐ One month's worth of **pay stubs** or a letter from the employer on their letterhead attesting to employment and compensation for everyone in your household.

If your income is over $50,000, provide the amount of your outstanding medical bills;
Insurance premiums _______ Medication costs _________ Hospital bills ___________
Other ____

Please respond to the following questions:

1. Are you receiving Pharmacy Benefits paid for by Medicare, Medicaid, or any Federal or State funded insurance program? ☐ **Yes** or ☐ **No.**

2. Do you agree to be fully compliant in taking the drug for which financial assistance is being provided in accordance with your doctor's directions? ☐ **Yes** or ☐ **No.**

3. In addition to providing financial assistance, the Chronic Disease Fund provides you with free access to the online therapy management tool found at *DiseaseTrak.com*. Will you be able to access the internet site? ☐ **Yes** or ☐ **No.**

Chronic Disease Fund

Date:	*How much can you afford for this medication?* ______ *You may be responsible for any remaining balance CDFund does not cover.*	
PATIENT INFORMATION		
Patient's name:	Spouse or Parent's Name:	Birth date:
Number of people in household:	Annual Household Income:	Mailing address:
City:	State:	ZIP Code:
Home phone:	Cell phone:	Work phone: Ext:
E-mail Address:		
MEDICAL AND INSURANCE INFORMATION		
Diagnosis:	Medication:	Dosage:
Pharmacy:		
Physician Name:	Physician Phone:	
Major Medical Insurance Plan Name:	Subscriber Employer:	
Drug Card Insurance Name:	Is this a Medicare part D plan? ☐ Yes ☐ No	Employment Status: ☐ Retired ☐ Employed ☐ Disability ☐ Unemployed

Agreements:

Certification and Acknowledgement: You agree that all of the information you have provided is truthful and accurate to the best of your knowledge. You understand that you are free at any time to switch providers, practitioners, suppliers, or covered specialty therapeutics without affecting your continued eligibility for assistance. Your application for assistance does not guarantee funding will be available. Any financial assistance that you may be eligible for will only be awarded after documentation of your first dispense has been approved by CD Fund. You understand that if you are awarded financial assistance that it will be provided on a Calendar Year basis. You must reapply each Calendar Year and the end of the Calendar Year is your notice of cancellation. There is no guarantee that funding will be available in any subsequent year.

Limitation of Liability. You agree that the Chronic Disease Fund, the Chronic Disease Management Group, Inc., DiseaseTrak, Inc., our sponsors, and our donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-pay relief, or other value-added benefits or services provided as a part of this program.

Your Printed Name: ________________________ Date: ____________________

Your Signature: __________________________________

Please fax or mail this entire document along with a copy of your:

☐ **Financial documents** ☐ **Insurance cards**

to (214) 570-3621 or mail to the address provided below:

Chronic Disease Fund Attn: Enrollment
6900 N. Dallas Parkway, Suite 200, Plano, TX 75024

Chronic Disease Fund

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations
I hereby authorize the use or disclosure of my individually identifiable health information ("Protected Health Information") as described below in this form (this "Authorization") by Chronic Disease Fund, a non-profit organization ("CDFund").

Patient Name: ________________ ID Number or SS#: _____________

Name of person(s) or organization(s) authorized to use or receive the Protected Health Information: **Support Agency, CDMG Inc., DiseaseTrak, Inc., and Non-Profit Organizations**

Specific description of Protected Health Information to be used or disclosed:
To Support Agency, CDMG Inc., DiseaseTrak, Inc., or Non-Profit: patient demographic and contact information, including physician, disease, and drug treatment information.

Please fill out an event on which this authorization will expire or a date (do not select both):
Upon written request from patient

Please read the following:

1. I understand that my Protected Health Information may be subject to re-disclosure by the authorized recipient of the Protected Health Information pursuant to this Authorization. I further understand that if the entity or the organization that I authorize to receive my Protected Health Information under this Authorization is not a health plan, a health clearing house or healthcare provider, the released Protected Health Information may no longer be protected by federal privacy regulations.
2. I understand that I may revoke this Authorization at any time by notifying CDFund in writing, but if I do, it will not have an effect on any actions CDFund took before it received the revocation of this Authorization. Revocations must be sent to:
   CDFund, N. Dallas Parkway, Suite 200, Plano, TX 75024.
   Attention: Clorinda Walley RE: Revocation

Section B: CDFund must complete only if CDFund requested this Authorization:
What is the purpose of the use or disclosure? **To make determinations for financial assistance and to request donations, training, education, and/or other assistance for Patients.**

Section C: The patient or the patient's representative must read and initial the following statements:

___ I understand that I may refuse to sign the Authorization, and that my health care treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this form. However, I understand that by **not** signing this document my financial assistance payment will only be available through the Reimbursement Program.
___ I understand that I have the right to receive a copy of this Authorization after I sign it.
___ I understand that I may see a copy of the Protected Health Information described on this Authorization if I request to do so.

Section D: Signatures – Must be completed for all Authorizations

____ ________________
Signature of Individual or Individual's representative Date
(Form MUST be completed before signing)

Print name of Individual's representative: *(If applicable)* ______________________________________

Relationship to the Individual: *(If applicable)* ____