2023-2024 "LIFELINE" Application

(For July 1, 2023 – June 30, 2024)

The **LIFELINE** program is to help with health insurance premiums, COBRA premiums, out-of-pocket medical expenses, and other costs related to the treatment and management of 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.

To be eligible for Lifeline assistance, you must meet all of these requirements:

1) You are a Utah resident, living in the state for the past 12 months or longer.
2) You are a United States citizen/permanent resident alien/or hold a valid visa.
3) You or someone in your household has a bleeding disorder.
4) Your total paid household medical expenses for the past 12 months are greater than 7.5% of the adjusted gross income* (AGI) on your most recent tax return.

*** 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 0.075)

(3) $ _____ Household's total medical expenses PAID BY YOU within the past 12 months

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.

Please submit ALL the following REQUIRED documents with this application:

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

1. Copy (front and back) of your **current health insurance card**

2. A **letter from the HTC**, a hematologist, or primary care physician verifying bleeding disorder(s) diagnosis *(see page 5 of application)* ****this is only necessary for first time applicants. This step is not necessary for re-applications to the program.***

3. **Proof of your familiy's out-of-pocket medical expenses for the previous 12 months.** To qualify for Lifeline assistance, your paid medical expenses must equal or exceed 7.5% of your AGI (Adjusted Gross Income) according to your most recent tax return. These expenses may include: health Insurance payments, COBRA payments, medical co-payments (for doctor, hospital, pharmacy), etc. These expenses can be for the entire family and include ALL medical expenses, not just those related to a bleeding disorder.

4. Check stubs for past 2 months for each employed adult in the household

5. Copy of first 2 pages of latest signed IRS tax return

6. Copy of a valid form of identification (current drivers' license, passport, etc.)

2023-2024 "LIFELINE" Application

Submit Completed Application to: ***Utah Hemophilia Foundation***
772 East 3300 South, Suite 205, Salt Lake City, UT 84106 or western@hemophiliautah.org

UHF OFFICE USE ONLY **Date Received @ UHF Office: _____**

Your First Name: _____ Last Name: _____

Current Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email: _____

How long have you lived at the above address*? _____

**If you have lived at current address less than one year, provide previous addresses for 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

2023-2024 "LIFELINE" Application

Please indicate with what expenses you require help (you may check more than one):

- ☐ Health Insurance Premiums
- ☐ COBRA Premiums
- ☐ 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 this 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: _____

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 employed? YES or NO

Name of Spouse's Employer: _____

Spouse's Employer's Address: _____

Spouse's Length of time with current employer: _____

2023-2024 "LIFELINE" Application

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/REQUST 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 Invoice	*Type of Expense* (insurance, COBRA, medical, etc.)	*TOTAL Amount You Owe*	*Total Amount YOU have paid towards invoice*	*Amount of assistance requested through LIFELINE*	*Have you enclosed copy of the bill or your receipt for payment (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

This page is ONLY required for your FIRST Lifeline application.

If you have previously applied to Lifeline, do not submit this form.

Instructions to Lifeline Applicant:

As part of the the Utah Hemophilia Foundation (UHF) must have documentation of your diagnosed bleeding disorder. *Please submit this completed form to your medical provider to authorize him/her to share information about your bleeding disorder diagnosis with the UHF.*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, authorize _____
(Applicant's first and last name) *(Applicant's physician or medical facility)*

to release medical information to the Utah Hemophilia Foundation (UHF), documenting the diagnosed bleeding disorder(s) that affect me and/or the members of my family. Please send this information to:

The Utah Hemophilia Foundation
772 East 3300 South, Suite 205
Salt Lake City, UT 84106
(801-484-0325)

OR

Email: western@hemophiliautah.org

Fax: 801-746-2488

_____
Applicant signature Date

_____
Applicant phone number Applicant Email Address

**Any and all patient information submitted to the Utah Hemophilia Foundation will remain confidential and will not be shared. Information will be used, only, in conjunction with the patient's Lifeline application for financial assistance.*