Chronic Disease Fund cdf

2014 Patient Application

PATIENT NAME _____ **SSN:** _____

Welcome to Chronic Disease Fund, a non-profit organization whose financial assistance programs provide thousands of individuals diagnosed with life-altering diseases the opportunity to get the medications they need to help improve their quality of life.

In order for us to begin the process of qualifying you for financial assistance, please complete the application and return it to Chronic Disease Fund, along with verification of your household income and copies of your insurance card(s). Completed applications can be received via mail, fax or online submission. Details of acceptable documentation and submission options are outlined on page two.

Upon receipt of your completed application, Chronic Disease Fund will determine if you are eligible for financial assistance based on our Program Guidelines and subject to available funding. We will advise you and/or your medication provider of the final outcome.

If you qualify and if funding is available, we will provide you with financial assistance for the remainder of the calendar year. We will also provide you with a username and password so that you may freely access our therapy management portal found at PatientsandPros.cdfund.org.

Please understand that all approvals are based on available funding and are approved on a first-come, first-served basis. **Receipt of application does not guarantee funding**

Please call us toll-free at (877) 968-7233 if you have any questions or need assistance filling out the following enrollment forms.

Sincerely,
Chronic Disease Fund

Required Documentation & Submission Options

Documentation Required

1. Pages 3-5 signed and dated where applicable along with household income documentation.

2. A copy of the front and back of the Patient's insurance cards

3. Documents supporting household income level MUST be **ONE** of the following:

   - 2012 tax return
   - 2012 Letter from Social Security stating income for each member in patient's household
   - 2012 W-2s or 1099s for patient's household
   - One month of pay stubs or a letter from each employer on company letterhead attesting to employment and compensation for each member in patient's household for 2012
   - Copy of patient's most recent bank statement

Submission Options

1. FAX: (214) 570-3621 or (214) 570-3622

2. MAIL: Chronic Disease Fund
   Attn: Enrollment
   1100 Valwood Pkwy, Ste. 104
   Carrollton, TX 75006

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:	Birth Date:
Alternate Contact:	Relationship:
Mailing Address:	Home phone:
	Cell Phone:
	Work Phone: Ext:
E-mail Address:	
INCOME INFORMATION	
Annual Household Income:	Number of people in household:
PHYSICIAN INFORMATION	
Physician Name:	Physician Phone:
Office Address:	NPI:
DIAGNOSIS INFORMATION	
Diagnosis:	
Medication:	
Pharmacy:	Pharmacy Address or Phone:

MAJOR MEDICAL INSURANCE INFORMATION		
Insurance Name:		
ID#:	Group #:	Phone:

DRUG CARD INFORMATION		
Insurance Name:	ID#	
BIN:	PCN:	Phone:
Is this a Medicare Part D Plan? Yes No		

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Chronic Disease Fund
Toll Free 877-968-7233 * Fax 214-570-3621 or 214-570-3622
Private and Confidential when completed

PATIENT ATTESTATION Please answer questions below	
Yes No	Are you receiving Pharmacy Benefits paid for by Medicare, Medicaid, or any Federal or State funded insurance or assistance program? *(Please see the Agreements and Certifications section below for further clarification.)*
Yes No	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?

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 specialty therapeutics within the CDFund formulary for your diagnosis 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 CDFund. 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, Sonexus Healthcare, 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.

Signature of Individual or Individual's representative	Date
Print name of Individual's representative: (If applicable)	Relationship (if applicable)

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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" or "PHI") as described below in this form (this "Authorization") by Chronic Disease Fund, a non-profit organization ("CDFund").

Name of person(s) or organization(s) authorized to use or receive the Protected Health Information:
Support Agency, Sonexus Healthcare, and Non-Profit Organizations

Specific description of Protected Health Information to be used or disclosed:
To Support Agency, Sonexus Healthcare, 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:
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 PHI pursuant to this Authorization. I further understand that if the entity or the organization that I authorize to receive my PHI under this Authorization is not a health plan, a health clearing house or healthcare provider, the released PHI 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 6900 N. Dallas Pkwy, Ste. 200 Plano, TX 75024
Attention: HIPAA Security Officer 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

Section C: The patient or the patient's representative must read 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 PHI described on this Authorization if I request to do so.
-

Section D: By signing below you agree that you have read and understand the above statements.

_____ _____
Signature of Individual or Individual's representative Date

_____ _____
Print name of Individual's representative: (If applicable) Relationship (if applicable)

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