



ASSISTANCE PROGRAM APPLICATION

PAGE 1

2614 W. Jefferson St.
Joliet, IL 60435
(815) 725-1355

Thank you for your interest in the JOHA Foundation's Assistance Program.

Our mission is to enhance the quality of life of cancer patients and of the community, by providing education and various means of support for all cancer patients. Please take a few minutes and review the application for the Foundation's financial assistance programs and let us know if you have any questions. You can reach a JOHA Foundation Board member at (815) 725-1355. We look forward to the opportunity to serve you.

The checklist below can help you track the paperwork necessary to process your assistance application. Check each document when completed:

- Completed application
- Signed Patient Responsibilities and Release Consent Form
- Proof of all household income (Please see below for explanation)

Premium Assistance Loan Applicants will also need to include:

- Proof of health insurance premium (Please see below for explanation)

What is proof of income? Any document that shows the amount of total income. Examples include: Federal income tax return, most recent pay check stub, W-2, Form 1099, SSI or SSDI determination letter, Social Security benefit letter, pension statements.

What is proof of premium? Any document that shows the amount paid for an insurance premium on your pay check stub, bank statement, canceled check, monthly billing statement, payment coupons, and/or a letter from your insurance company stating the cost (this includes COBRA).

Proof of premium is only required if applying for a premium assistance loan.

JOHA Foundation Types of Assistance

- **RX ASSISTANCE** – Provides financial assistance to underinsured patients who are acquiring prescription medication and/or prescription orthotics (examples: wigs, forms) relating to their cancer diagnosis.
- **NUTRITION ASSISTANCE** – Provides financial assistance to cancer patients who are unable to financially support their nutritional needs.
- **HOUSING ASSISTANCE** – Provides financial assistance to cancer patients that need temporary housing arrangements close to the location in which they are currently undergoing treatment at.
- **MISCELLANEOUS ASSISTANCE** – Provides financial assistance for miscellaneous types of needs that are necessary to continue cancer treatment.
- **PREMIUM ASSISTANCE LOAN** – Provides financial assistance as a non-interest bearing loan, to cover the cost of a cancer patient's monthly insurance premium or COBRA payment, to ensure the cancer patient receives the same level of continued covered care while undergoing treatment. The loan would be paid back per the attached promissory note.



Please complete all sheets of this application
You must sign page 4.

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Please Print

First Name: MI: Last Name:

Mailing Address: Street City/Zip

Home Phone #: Other Phone#: Gender: M F

Date of Birth: Social Security Number:

May the JOHA Foundation share your information with an alternate contact? Yes No (friend, advocate, etc.)
If yes, Name: Relationship Number:

Please indicate the type of assistance you are applying for from the list of JOHA Foundation Types of Assistance provided on the bottom of the checklist page (1).

*PATIENT ELIGIBILITY INFORMATION - ATTACH PROOF OF ANNUAL HOUSEHOLD INCOME

Total Annual Household Income (include all income, wages, Social Security, Pension, Disability, etc): \$
Number of people in household:

For RX ASSISTANCE - ATTACH RECEIPTS SHOWING THE AMOUNT PAID FOR OUT OF POCKET PRESCRIPTION COSTS AND FILL OUT THE INFO BELOW.

Please list all medicines you currently are taking and any medical conditions:

What is your monthly out of pocket expenses for prescription drugs (not over the counter)? \$
Do you have public or private prescription drug coverage? Y N
Are you currently enrolled in a Medicare Part D Prescription Drug plan? Y N

Please indicate any special circumstances for us to consider (you may attach an additional sheet to the application if necessary):

We will review your documentation for approval. However, since we are a charity there is no guarantee that funding will be available.



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PAGE 3

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DISCLAIMER

I verify that the information provided in this application is complete and accurate. I further understand that the JOHA Foundation is not responsible for the cancellation of any policy, prescription or treatment due to an applicant's failure to notify this organization of any and all changes with their Insurance Premium or out of pocket prescription expenses. Furthermore, the JOHA Foundation is not responsible for prescription or treatment cancellation due to an applicant's failure to submit the premium or out of pocket prescription expenses amount within the prescribed invoice period. I understand that I shall be required to return to the JOHA Foundation any refund money for my premium or out of pocket expenses received by me. Any refund money represents an overpayment by the JOHA Foundation for which full or partial payment was made by the Foundation. Any money given to me for the purpose of continuing payments for my insurance coverage (Premium Assistance Loan) is considered a non-interest bearing loan and it is the expectation that I pay it back to the JOHA Foundation at a later time as I'm able.

ENROLLMENT

By submitting this application the applicant is requesting enrollment in the Assistance Program provided by the JOHA Foundation and understands that all decisions made regarding the Assistance Program and eligibility will be made by Board Members of the JOHA Foundation. Upon submitting an application the applicant understands that the JOHA Foundation Board will review the application form, determine eligibility, and notify the applicant based on the information the applicant provides. The applicant also understands that while due consideration is made of the application; the Board retains the absolute discretion to allow or disallow assistance. In order to determine eligibility the applicant understands that the Board may require additional information from the applicant, and the applicant must provide the requested information and may be found ineligible for assistance if he/she does not. The applicant also understands that because the JOHA Foundation is a charity, there is no guarantee that funding will be available.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

The applicant understands that in order to be eligible for the Assistance Program the applicant must provide the JOHA foundation with his or her personal, financial and other information, including the prescription products that the applicant currently uses and receives. By signing this application, the applicant authorizes the JOHA Foundation to use his or her information for the sole purpose of implementing and administering the Assistance Program and to communicate with the applicant regarding the same. The applicant understands that the JOHA Foundation will not use his or her information for any other purpose unless specifically authorized to do so.

LIMITATIONS

All Assistance Program payments made to patients or to their insurance company, will be made via check. Patients who have already received the maximum assistance allowed (determined upon approval) must resubmit an updated application and documentation as outlined herein in order to receive additional assistance.

WHO QUALIFIES

Any cancer or hematology patients may qualify for assistance under the Assistance Program if they meet multiple criteria, some of which include:

1. They have no insurance, private insurance, or a Medicare Part D plan but cannot afford their out of pocket prescription drug expenses.

- 2. They have an annual household income of:
 - a. \$32,490 or less for a single person; or
 - b. \$43,710 or less for a family of two; or
 - c. \$54,930 or less for a family of three; or
 - d. \$66,150 or less for a family of four; *Add \$11,220 for each additional person.

*If your annual household income exceeds those outlined above, you may still be eligible. Each application will be reviewed and assistance will be provided on a case-by-case basis.

- 3. They are unable to pay for their monthly insurance or Cobra premium.
- 4. They currently have special circumstances which is affecting their financial situation.

REQUIRED INFORMATION

To be eligible for assistance, each applicant must do the following:

- 1. Fill out the attached application form and sign the application below.
- 2. **Attach a photocopy of his or her ANNUAL household income** (Federal tax form (1040), Request for Transcript of Tax Return (Verification of non-filing form 4506-T), social security income (SSA 1099), pensions, interest, retirement, child support, letter from healthcare professional, shelter or patient advocate, Healthcare Provider (clinic, shelter, etc), income pre-certification statement),
- 3. **Attach a photocopy of his or her receipts for pharmacy prescriptions or prosthetics.**

Incomplete or incorrect applications will not be considered for assistance until all required information is provided and correct. To avoid unnecessary delays please make sure all information provided is accurate and complete before submission.

Completed applications may be faxed or mailed to the JOHA Foundation Board.

Fax number: 815-725-9861
 Mailing Address: The JOHA Foundation
 2614 W. Jefferson St.
 Joliet, IL 60435

ATTESTATION

I attest that the information provided in this application is complete and accurate. I understand that the JOHA Foundation reserves the right to refuse my application based on any misuse, abuse, or fraudulent information provided. I understand that it is unlawful to knowingly submit false information to obtain financial assistance. I verify that I have read, understand, and agree to the responsibility of the enclosed JOHA Foundation Notice of Privacy Practices regarding the Health Insurance Portability and Accountability Act of 1993.

Responsible Party Signature _____ Date Completed _____

Print Name: _____

For Office Use Only: Approved ____ Denied ____ Date Issued _____ Check # _____

Type of Assistance _____

If Premium Assistance Loan, attach additional information.



JOHA Foundation Notice of Privacy Practices PAGE 5

2614 W. Jefferson St.
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*This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.
Effective October 1, 2010*

In compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") we are required to (i) maintain the privacy of your protected health information ("PHI"; written and/or oral), (ii) provide you with notice of our legal duties and privacy practices with respect to your PHI, and (iii) abide by the terms of this notice.

We reserve the right to change the terms of this notice at any time and to make the new terms effective for your PHI maintained at that time. In the event of a material change in the terms of this notice, we will provide you with a revised notice by mail. For further information about our privacy policy, please contact our Privacy Officer at 815-725-1355.

Your PHI will only be used within the confines of the JOHA Foundation program(s) for purposes of treatment, payment, and health care operations, including, but not limited to, the following: verifying your submitted application information with your physician's office, clinic, treatment center, referral agency, health insurance company, pharmacy, nursing service, guardian, and provider of service. Your PHI will not be used or shared with any entity or person outside the aforementioned, unless specifically authorized by you in writing, which such authorization you may revoke at any time.

You have the following rights with respect to the PHI we maintain about you: (i) the right to request restrictions on certain uses and disclosures of your PHI (although the JOHA Foundation is not required to agree to any such requested restriction); (ii) the right to receive confidential communications of your PHI; (iii) the right to inspect and obtain a copy of your PHI; (iv) the right to amend your PHI; and (v) the right to receive an accounting of the disclosures of your PHI. You may exercise your rights by contacting our Privacy Officer at 2614 W. Jefferson St., Joliet, IL 60435.

Please be advised that if you place any restrictions on the uses and disclosures of your PHI within the stated JOHA Foundation uses and disclosures, which may be contrary to JOHA Foundation eligibility criteria, you may not be eligible for our assistance. The JOHA Foundation may continue to use your PHI within the aforementioned parameters as long as you receive active assistance. Upon being closed to assistance, your file will be archived for a period of six years in which the requirements of this policy will remain in-force after which time the files will be purged and destroyed.

If you believe that your privacy rights have been violated, you may submit a complaint in writing to 2614 W. Jefferson St., Joliet, IL 60435. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.