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

# ASSISTANCE PROGRAM APPLICATION



## 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 various means of temporary assistance 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**
- **Proof of all household income**

**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.

## JOHA Foundation Types of Assistance

- **RX ASSISTANCE –** Provides assistance to underinsured patients who are acquiring prescription medication and/or prescription orthotics (examples: wigs, forms) relating to their cancer diagnosis.

- **NUTRITION ASSISTANCE –** Provides assistance to cancer patients who are unable to financially support their nutritional needs.

- **TRANSPORTATION ASSISTANCE –** Provides assistance to/from Presence Cancer Care for patient's medical visits.

- **MISCELLANEOUS ASSISTANCE –** Provides assistance for miscellaneous types of needs that are necessary to continue cancer treatment. *You must indicate specifically what it is that you need help with.

**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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## 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.

## 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 other entities 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.

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

- They have an annual household income within the Federal Poverty Guidelines for Illinois.

- They have/are:
  - Under insured.
  - Self-pay.
  - High out-of-pocket medical expense.
- 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 ANNUAL household income**. **Example: Recent Federal or State Tax Return.**
   ***If you weren't required to file taxes, you must show proof of income (social security statements, pensions, etc).**
3. **Attach proof of monthly expenses (i.e.: electric, gas, water, loans etc.)**
4. **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- 9862
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 _____**

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# JOHA Foundation Notice of Privacy Practices



***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.