Assistance Fund
4700 Millenia Blvd., Suite 310
Orlando, Florida 32839

To whom it may concern,

Thank you for your interest in The Assistance Fund. The Assistance Fund established the Multiple Scleriosis Copay Assistance Program to assist patients who have primary insurance but need help with their copay for specialty medications.

How do you apply for assistance?

Please follow the steps listed below.

1. **Complete the attached Enrollment Application in full including signature on page 3**
2. **Mail or Fax the completed and signed application pages 1, 2 and 3 to:**
   - **Address: The Assistance Fund – 4700 Millenia Blvd., Suite 310 – Orlando, Florida 32839**
   - **Fax: (866) 254-9411**

We will accept and process completed enrollment applications only. Incomplete or incorrect enrollment applications will delay the process. Once we receive the completed enrollment application, final evaluation and program eligibility will be determined.

If you have any questions or concerns, please contact a Patient Advocate Monday through Friday from 9:00AM – 6:00PM (Eastern Standard Time) excluding holidays by phone at (877) 245-4412. No response will result in the discontinuation of your financial assistance through the Multiple Sclerosis Copay Assistance Program.

Sincerely,

The Assistance Fund Program Team

Q4 2013 MS Copay Assistance Enrollment Application

Completing the application does not guarantee acceptance in the Multiple Sclerosis Copay Assistance Program. For questions, please contact a Patient Advocate Monday – Friday from 9:00AM – 6:00PM excluding holidays (EST) at **(877) 245-4412.**

Patient Information – Please Complete in Full

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Patient Legal Last Name:	Legal First Name:	Marital Status: ☐ Married ☐ Single	TAFID:
Primary Phone: ☐ Home ☐ Cell ( )	Secondary Phone: ☐ Home ☐ Other ( )		Last 4 digits of Social Security Number: XXX – XX - __ __ __ __
Mailing Address or P.O Box:	E-mail Address:		TAF may contact me via text message or Email regarding my assistance. ☐ Yes ☐ No
City:	State:	Zip Code:	Are you a U.S Veteran: ☐ Yes ☐ No
Gender: ☐Male ☐Female	Date of Birth (MM/DD/YYYY) / /	Are you a U.S. citizen or permanent resident? ☐ Yes ☐ No	Diagnosis:
Race/Ethic Origin: ☐ Native American ☐ Hispanic or Latino ☐ White ☐ Asian ☐ Black or African American ☐ Hawaiian ☐ Other ____________			Prescribed Medication:
Alternate Contact First and Last Name:	Relationship to Patient:	Contact Phone: ☐ Home ☐ Cell ( )	

Insurance and Pharmacy Information

Insurance and Pharmacy Information

Do you have health insurance? ☐ Yes ☐ No (**If Yes** - Check all that apply):

☐ Not Applicable ☐ Medicare ☐ Medicaid ☐ State Medical Aid ☐ Commercial Coverage ☐ Health Exchange

Does your health insurance cover the prescribed medication listed above? ☐ Yes ☐ No

Are you in the process of securing Health Insurance Coverage for the Prescribed Medication? ☐ Yes ☐ No

Name of Insurance:		Cardholder First and Last Name:	Relationship:
Member ID #:	Group #:	Phone: ( )	Secondary Phone: ( )
Pharmacy Name dispensing the medication **or Office / Location Name** where the medication will be administered:			
Pharmacy Phone Number: ( )		**Office / Location** Phone Number: ( )	
Pharmacy Fax Number: ( )		**Office / Location** Fax Number: ( )	

Income Information

Income Information

Household Size: # of people who contribute to or are dependent on your current annual household income including yourself

(Check appropriate box) 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ Other ____ (list number of people)

Current Annual Household Income based on Above Household Size: **$** ______________ (Specify Below)

☐ Salary/Wages: $______________	☐ Alimony: $______________________________
☐ Social Security: $______________	☐ Interest/Dividends/Annuities: $________________________
☐ Social Security Disability: $________	☐ Income Assistance (Other Government Entitlements): $__________
☐ Pension:$ ____________________	☐ Unemployment Compensation:$________________________
☐ Other:$____________________	

Q4 2013 Program Enrollment Agreements

Compliance: I understand that if I am accepted into programs offered by The Assistance Fund that financial assistance is being provided to help me afford my medications, my health insurance premiums and/or my basic need costs. Therefore, I agree to take my medications for which I receive financial assistance from The Assistance Fund and/or agree to timely pay my health insurance premiums and/or basic needs for which I receive financial assistance from The Assistance Fund. In the event that I do not comply with my medication regimen, pay for my health insurance premiums or pay for my basic needs as agreed, then I may be removed from participation in the programs offered by The Assistance Fund.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I understand that at any time during my enrollment in a program at The Assistance Fund that I may be contacted to request documentation of the Income Information and Household Size that I provided in my enrollment application for participation in such program(s). I understand that if The Assistance Fund requests evidence to support my Income Information or Household Size that I must respond to The Assistance Fund and submit the requested information within the designated timeframe provided. If I fail to submit the requested documentation within the designated timeframe, I may be terminated from the program.

I understand that I am free at any time to switch healthcare providers, practitioners, pharmacies, insurers or other healthcare suppliers without affecting my continued eligibility for assistance. I understand my application for assistance does not guarantee funding is or will be available. I understand that if I am approved for participation in a program, such financial assistance is provided for up to twelve months. Thereafter I must reapply for assistance each twelve months. Assistance in any year is always subject to the availability of funds and there is no guarantee such funds will be available.

Provision of Assistance: I acknowledge that The Assistance Fund provides financial assistance to individuals who qualify for participation pursuant to the rules established by The Assistance Fund. I further agree that if approved for financial assistance, my participation requires that I meet the program rules throughout the period of time that I receive assistance from The Assistance Fund.

Change in Insurance, Household Income/Household Size, or Other Information Provided in this Application: I agree that at any time that I am receiving assistance from The Assistance Fund if my insurance benefit changes, if I am no longer in need of assistance, in need of less assistance, or my household income or household size changes, I will immediately notify The Assistance Fund with such change. Changes may impact my participation in The Assistance Fund program(s) including a reduction in the amount of assistance provided or a termination of assistance entirely. All provisions of assistance are based upon the program rules established by The Assistance Fund and not all applicants are eligible for participation.

Furthermore, if I begin receiving government benefits and any portion of the benefits are for retroactive financial assistance, I am responsible for reimbursing The Assistance Fund for the same amount of retroactive assistance that I received under this program.

Waiver and Release of Liability: I understand that if I am enrolled in The Assistance Fund's health insurance premium assistance program that, at the option of The Assistance Fund, funds may be paid directly to my insurance provider or to me as reimbursement for my payment to my insurance provider. I understand that the amount of assistance that I receive may only partially cover my insurance premiums. If the assistance only partially covers my insurance premiums, I understand that I have the responsibility to pay the balance of such premiums in order to fulfill my financial obligation with my insurer. I understand that a policy of insurance that is underwritten to cover me is my responsibility and that I retain the responsibility to ensure that the related insurance premiums are paid in accordance with the insurance contract terms and conditions. I hereby release The Assistance Fund from liability and forever waive my right to make a claim against The Assistance Fund for the cancellation of, non-renewal of, or denial of insurance (or any such application of insurance). I agree that it is my obligation to contact The Assistance Fund if I receive a notice of cancellation, non-renewal, or denial of insurance as such information may impact my ability to receive assistance from The Assistance Fund for such program.

Patient Authorization to use or release Protected Health Information: I authorize the use and disclosure of my individually identifiable health information ("Protected Health Information") by The Assistance Fund, Inc, a non-profit organization, to process my application for program participation, if I am determined eligible and funds are available - to enroll me in a program(s), and to use and disclose my Protected Health Information to investigate my eligibility for assistance with other assistance programs, where applicable. I authorize my health care provider and insurance benefit provider (including my insurance benefit providers' administrator – if any) to disclose to The Assistance Fund, Inc. my health information (orally or in writing) for the purposes herein. I also authorize The Assistance Fund and its third party contractor to use my Protected Health Information for the purpose of analyzing and evaluating The Assistance Fund's programs to determine trends in insurance reimbursement, patient therapy compliance and other related statistics related to The Assistance Fund programs. De-identified data may be used as permitted by law. I understand that once my Protected Health Information is released pursuant to this authorization that it may be subject to re-disclosure. I may withdraw this authorization at any time by mailing or faxing a letter of revocation to The Assistance Fund at the address listed herein below; provided that such revocation will not have an effect on any actions taken by The Assistance Fund prior to The Assistance Fund's receipt of my revocation of Authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through The Assistance Fund's Programs. This authorization expires annually. I understand that I may request an accounting of disclosures of my Protected Health Information by The Assistance Fund if I request it in writing and send it to The Assistance Fund, Inc. 4700 Millenia Boulevard, Suite 310, Orlando, FL 32839.

________________________________ ________________________

Signature of Patient or Patient's Representative (*if applicable)*

Date

________________________________ ________________________

Print Name of Patient or Patient's Representative *(if applicable)*

Relationship to Patient *(if applicable)*