	Illinois Department of Healthcare and Family Services ATTN: Hemophilia Program P.O. Box 19129 Springfield, IL 62794-9129	For Office Use Only Identification Patient Number

APPLICATION TO THE STATE HEMOPHILA PROGRAM				
Patient Name: (First) **Mr.** ☐ **Mrs.** ☐ **Miss** ☐		**(Middle)**	**(Last)**	
Date of Birth	**Social Security Number**		**Sex** **Male** ☐ **Female** ☐	
Patient's Permanent Address	**City**	**State**	**Zip code**	**County**
Home Telephone Number	**Work Telephone Number**		**Cell Phone Number**	

Patient's Hemophilia Physician		**Social Worker Name**	
Name of Hemophilia Treatment Center		**Address of Hemophilia Treatment Center**	
City	**State**	**Zip code**	**County**
Last Date of Comprehensive Visit	**Next Comprehensive Visit**	**Diagnosis**	

**An eligible person shall have a complete yearly comprehensive care evaluation in a Hemophilia Treatment Center. A written statement by the center director indicating that the comprehensive care evaluation has been performed shall be sent to the State Hemophilia Program each year.* Failure to comply will result in the termination from the program. HFS 89 ILLINOIS ADMINISTRATIVE CODE Chapter 1, Section 146.430 Subchapter d Section 146.430

Members of family living in household, including patient. Please list head of household first		
Name	**Age**	**Relationship to Patient**

Major Medical Insurance and Prescription Drug Information *(please include copy of insurance card(s)*		
Insurance Company Name	**Policy Holder**	***Policy Number - -Group- Individual***
Prescription Drug Plan (if separate from Medical Insurance)		***Policy Number - -Group- Individual***
What percentage does your insurance (or drug plan) pay towards the cost of factor? ☐ **60%** ☐ **80%** ☐ **100%** ☐ **Other**		**Please disclose monthly premium costs**

IMPORTANT NOTICE: This State Agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83-99. Disclosure of this information is mandatory.

I hereby certify that the answers given on this application and financial profile are correct and true to the best of my knowledge. I authorize the Illinois Hemophilia Program or its representatives to verify all facts herein stated relative to my financial condition or income. I consent to the furnishing by physicians or hospitals of any information requested by the Illinois Hemophilia Program regarding my diagnosis or treatment. A photocopy of this consent will be as valid as the original. It is understood that all information will be treated as confidential.

REV 4-1-14

PLEASE ATTACH A COPY OF YOUR MOST RECENT STATE INCOME TAX RETURN (FORM IL-1040).

If patient is a minor, and included in parent's or guardian's State Income Tax Return.

Patient and members of family living at home – employed during the past year. If patient is a minor, include parent's or guardian's income.				
Name	**Place of Employment**	**Annual Income During Past Year**	**Current Monthly Income**	**If Currently Unemployed, State Why and Last Day of Employment**

Other Income During Past Year

Unemployment Compensation: $_____ x _____ Months, or $_____ Total

Disability or Pension: $_____ x _____ Months, or $_____ Total

Social Security Income: $_____ x _____ Months, or $_____ Total

Other Income: $_____ x _____ Months, or $_____ Total

Please specify other income:

_____

Signature: _____	**Date:** _____ **Mo Day Year**
(Patient signature – If minor, parent or guardian signature)	

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RELEASE OF INFORMATION

By signing this form, I _____ authorize Illinois Hemophilia
(First Name Last Name)
Program to release or retrieve any information, including protected health information or PHI, to any insurance company, insurance company representative or other authorized third party for the purpose of paying my claims. I authorize any holder of healthcare information or documentation, including PHI, needed to determine benefits or benefits payable for related services or any service rendered to me now or in the future to be released to Illinois Hemophilia Program if requested. I authorize that direct payment be made by any insurance company or other third party for any hemophilia charges that are reimbursable and owed to Illinois Hemophilia Program.

Signature: _____	**Date:** _____ **Mo Day Year**
(Patient signature – If minor, parent or guardian signature)	

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