The Assistance Fund™

4700 Millenia Blvd., Suite 410 Orlando, Florida 32839

Hello!

Thank you for your interest in The Assistance Fund (TAF). TAF was established to help patients facing high medical out-of-pocket costs by providing financial assistance for their copayments, coinsurance, deductibles and other health-related expenses.

Do I Qualify?

Patients must meet the following criteria to be eligible for participation in a TAF program:

- The patient must have (or be in the process of securing) health insurance coverage with a prescription drug benefit that covers his or her qualifying medication.
- The patient must be diagnosed with the disease state for the assistance program to which he or she is applying.
- The patient's medication must be an FDA approved medication for the treatment of the disease to which he or she is applying.
- The patient's household income must fall at or below the Federal Poverty Level outlined within TAF's program guidelines.
- The patient must be a U.S. citizen or permanent resident who resides and receives treatment within the United States or U.S. Territories.

For more information, please see our eligibility criteria located at https://tafcares.org/patients/eligibility/

How Do I Apply For Assistance?

Patients must complete an Enrollment Application, sign the Program Enrollment Agreements and HIPAA Release and return the full application for review while the program is accepting new enrollments.

- Complete sections 1 through 5 of the attached Enrollment Application in full including signatures on page 4 and 5.
  - *If signed by a Medical Proxy or POA, the applicable documentation must be submitted along with the completed application.*

- Submit the completed and signed Enrollment Application via one of the following methods:
  - Electronic Document Upload: https://tafcares.org/upload, or
  - Mail: The Assistance Fund – 4700 Millenia Blvd., Suite 410 – Orlando, Florida 32839, or
  - Fax: (833) 865-3757

Please note: Only fully-completed applications will be processed for final evaluation to determine eligibility. Incomplete or incorrect applications will cause delay. Completing the application does not guarantee acceptance in a program(s).

If you have any questions, please contact one of our **Patient Advocates** Monday through Friday, 9 a.m. – 6 p.m. (ET) at (855) 845-3663.

Sincerely,

The Assistance Fund

The Assistance Fund™

Patient's Full Name *(Last, First)*: _____

Patient's Date of Birth *(MM/DD/YYYY)*: ____/____/____

2019 Enrollment Application

(1) PATIENT INFORMATION (all fields required)

Patient Name *(Last, First)*:		DOB: __ __ / __ __ / __ __ __ __
Patient Address:		
City:	State:	Zip:
Are you a US Citizen or Permanent Resident? ☐ Yes ☐ No	Gender: ☐ Female ☐ Male	Race/Ethnicity:
Primary phone: ☐ Home ☐ Mobile ☐ Work (__ __ __) __ __ __ - __ __ __ __	Secondary Phone: ☐ Home ☐ Mobile ☐ Work (__ __ __) __ __ __ - __ __ __ __	Are you a US Veteran? ☐ Yes ☐ No
Email:		
May we contact you via text message and/or email? ☐ Yes ☐ No		
Contact Name *(if other than the patient)*:	Contact Phone: __ __ __ - __ __ __ - __ __ __ __	Relationship to Patient:
Total Number of People Within Household (Including applicant):		
Total Annual Income for Entire Household:		

(2) PRESCRIPTION COVERAGE AND INSURANCE INFORMATION (all fields required)

Do you have health insurance coverage? ☐ Yes ☐ No	If No, are you in the process of securing health insurance coverage? ☐ Yes ☐ No

What type of insurance coverage do you have? (Check all that apply)

☐ Commercial ☐ Health Exchange ☐ Medicaid ☐ Medicare ☐ VA/Tricare

Do you have prescription drug coverage for the prescribed medication? ☐ Yes ☐ No

(3) DIAGNOSIS AND PROGRAM INFORMATION

TAF Program Name *(for which you are seeking assistance):*	
Please provide the name(s) of the FDA approved medication(s) (*for which you are seeking assistance*):	
Diagnosed disease state and, If available, please enter the ICD-10 code(s) for your diagnosis:	

Patient's Full Name *(Last, First)*: _____

Patient's Date of Birth *(MM/DD/YYYY)*: ____/____/____

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, other basic needs and/or incidental medical-related expenses. 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, the costs of my basic needs and/or my incidental medical-related expenses for which I receive financial assistance from The Assistance Fund. In the event that I do not comply with my medication regimen or pay for my health insurance premiums, the costs of my basic needs or my incidental medical-related expenses as agreed, I no longer require financial assistance as evidenced by my lack of requests for and receipt of assistance, or I do not comply with The Assistance Fund's rules, policies and procedures that apply to the program(s) I am enrolled in, then I will be removed from participation in the program(s) offered by The Assistance Fund. If I am receiving assistance with genetic testing, I may not receive additional financial support unless I am diagnosed with a specific covered disease state and can provide evidence of such diagnosis.

Certification and Acknowledgement: I agree that all of the information I have provided is truthful and accurate to the best of my knowledge. I certify that I have been diagnosed with the disease state(s) covered by the program(s) I have applied for. Any personally identifying information provided to The Assistance Fund is subject to The Assistance Fund's privacy policy, the terms of which are incorporated herein and available at https://tafcares.org/privacy-policy/ or upon request. I understand that The Assistance Fund is required to screen all applicants for compliance with its designated financial and other eligibility criteria prior to enrollment in its programs or within a reasonable time thereafter. I understand that The Assistance Fund contracts with a third-party vendor to verify the Income Information and Household Size I provide in my enrollment application. I authorize The Assistance Fund to verify my Income Information by obtaining, either directly or through a third-party vendor, a consumer credit report from a credit reporting agency. I understand that this soft inquiry or "soft pull" will not impact my credit score. I understand that it may be visible to me when I view my credit report, but it will not be visible to other lenders or persons viewing my credit report for credit application purposes. I further understand that, at any time during my enrollment in a program at The Assistance Fund, 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 (or its third-party vendor) requests evidence to support my Income Information or Household Size, I must respond to The Assistance Fund (or its third-party vendor) 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 removed from the program.

I understand that I am free at any time to switch healthcare providers, practitioners, pharmacies, insurers (unless the program I am enrolled in is restricted to Federal health care plans, only) or other healthcare suppliers without affecting my continued eligibility for assistance. I agree that I will utilize the least expensive pharmacy benefit available under my insurance plan for medications that are covered under The Assistance Fund program that I am enrolled in. I understand that 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 on a calendar year basis and all claims must be submitted by March 31 of the following calendar year (unless otherwise specified for the applicable program). Thereafter, I must reapply for assistance each calendar year. Assistance in any year is always subject to the availability of funds and there is no guarantee such funds will be available.

By providing my telephone number and signing below to apply for service with The Assistance Fund, I hereby consent to receive telephone calls and/or text messages, including those made with an automatic telephone dialing system and/or pre-recorded voice, at the phone number I provide. The Assistance Fund will only call or text the number provided in connection with my application or enrollment with The Assistance Fund or to solicit donations. I hereby warrant that the phone number provided is registered to me or I am otherwise an authorized user of the phone number.

I acknowledge that if I elect to participate in a study conducted by The Assistance Fund, the terms of this Agreement shall apply to such study. Once enrolled in a study, I understand that any identifying information that I provide may be used by The Assistance Fund to analyze and evaluate The Assistance Fund's programs, to determine trends in insurance reimbursement, patient therapy compliance and other statistics related to The Assistance Fund's programs. I authorize The Assistance Fund to use de-identified study data as permitted by law. I may terminate my participation in a study at any time by contacting The Assistance Fund.

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 any program rules, policies and procedures set by The Assistance Fund, which may change from time to time, throughout my enrollment in a program.

The Assistance Fund may provide financial assistance by issuing me a debit card that is funded pursuant to The Assistance Fund's policies and procedures. If I am entering this agreement as the parent or legal guardian of a patient under the age of eighteen (18), the debit card may be issued in my name and I will be required to provide The Assistance Fund with certain personal information (such as my date of birth and social security number), in addition the minor patient's information, to receive financial assistance in this manner.

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 Income Information or Household Size changes, I will immediately notify The Assistance Fund and provide such change(s). 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 program rules and policies established by The Assistance Fund and not all applicants are eligible for participation.

I understand that The Assistance Fund will routinely review my ongoing requests for financial assistance. I understand that The Assistance Fund may conduct certain program audits and if I do not provide information that is requested of me, I may be removed from a program. In the event that I have not requested nor received assistance for a period of time designated by The Assistance Fund for the program I am enrolled in, The Assistance Fund reserves the right to remove me from participation in the program(s) and if my needs change in the future, I would need to reapply to the applicable The Assistance Fund program(s).

Furthermore, if I begin receiving government benefits or any other subsidy and any portion of the benefits or subsidies are for retroactive financial assistance that The Assistance Fund already provided to me, I am responsible for reimbursing The Assistance Fund for the same amount of retroactive assistance that I received under this program. Out-of-pocket costs paid for by The Assistance Fund may not be submitted as claims for payment to any third-party payers, any other patient assistance foundations or accounts such as a Flexible Spending Account (FSA), a Health Savings Account (HSA), or a Health Reimbursement Account (HRA).

Waiver and Release of Liability: I understand that, if I am enrolled in The Assistance Fund's health insurance premium assistance program, 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(s). The Assistance Fund reserves the right to pursue all available legal remedies in the event that any of the information that I provide to The Assistance Fund which is relied upon is false or I otherwise fail to comply with The Assistance Funds rules, policies or procedures.

Signature of Patient or Patient's Representative
(*if Representative has Legal/Medical Proxy or POA)*

Date

Print Name of Patient or Patient's Representative
(if Representative has Legal/Medical Proxy or POA)

Relationship to Patient
(Legal authority to execute this authorization)

Telephone Number of Patient or Patient's Representative
(*if Representative has Legal/Medical Proxy or POA)*

Patient's Full Name *(Last, First)*: _____

Patient's Date of Birth *(MM/DD/YYYY)*: ____/____/____

Patient Authorization for the Release of Protected Health Information

I authorize my treating healthcare providers and insurance benefit providers (including my insurance benefit providers' administrator, if any) to disclose my health records and any individually identifiable health information ("Protected Health Information") contained therein to The Assistance Fund, Inc., a non-profit organization. The purposes of this disclosure are: (i) to allow The Assistance Fund to process my application for program participation and, if I am determined eligible and funds are available, to enroll me in a program(s), (ii) to investigate my eligibility for assistance with other assistance programs, where applicable, (iii) to analyze and evaluate The Assistance Fund's programs to determine trends in insurance reimbursement, patient therapy compliance and other statistics related to The Assistance Fund's 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 and may no longer be protected by the HIPAA Privacy Rule. I may withdraw this authorization at any time by mailing or faxing a letter of revocation to The Assistance Fund at: The Assistance Fund, Inc., 4700 Millenia Boulevard, Suite 410, Orlando, FL 32839. I acknowledge that such revocation will not have an effect on any actions taken by my treating healthcare providers, insurance benefit providers and insurance benefit providers' administrator, if any, prior to The Assistance Fund's receipt of my revocation of this authorization. If I revoke this authorization, I will no longer be eligible to receive assistance through The Assistance Fund's programs. This authorization expires on the date that I am no longer participating in any of The Assistance Fund's programs or five years from the date of execution, whichever is sooner.

_____ _____

Signature of Patient or Patient's Representative
(*if Representative has Legal/Medical Proxy or POA)*

Date

_____ _____

Print Name of Patient or Patient's Representative
(if Representative has Legal/Medical Proxy or POA)

Relationship to Patient
(Legal authority to execute this authorization)