For Office Use Only:
Application received on:_____________ by (initials)___________
Evaluation due date: _________________________
Pharmacy name______________________________
Pharmacy Phone #:___________________________

C O N F I D E N T I A L

ASTHMA AND ALLERGY FOUNDATION OF AMERICA, ST. LOUIS CHAPTER
1500 South Big Bend, Suite 1 South • St. Louis, MO 63117
Phone: (314) 645-2422 • Fax: (314) 645-2022 • Website: www.aafastl.org

PROJECT CONCERN
APPLICATION FOR ASSISTANCE

Please complete all the information on both sides of this application. We are sorry, but we cannot process incomplete applications.

Today's date: ______________________________

PERSONAL DATA

Child's Name: ____________________________________ Date of Birth: _________________________________

Phone: __________________________________

Address: ____

City: ___________________________ State:__________ Zip: ____________ County: ___________________

Parent / Guardian Name ____

Relationship to Child: ________________________________

Best phone number(s) where parent/guardian can be reached: __________________ Home / Cell / Work (please circle)

E-mail address (will be used for Project Concern communications only): ____________________________________

For Statistical Purposes only: ____Male ___ Female

___ African-American ___Asian-American ___ Caucasian ___ Hispanic/Latino ___ Native American/Alaskan Native

____ Bi/Multi-Racial ___ Hawaiian/Pacific Islander ___ Other ____

Check this box if you would be willing to share your story about managing asthma and/or allergies with AAFA and our donors.

HEALTH COVERAGE INFORMATION

1. Is your child covered by any kind of health coverage or insurance? _____Yes ______No
   Check which of the following apply:
   Private Insurance: ______ Medicaid: _____ MO HealthNet for Kids: ______ IL All Kids: _____
   Insurance Information:
   Name of Health Insurance Provider____
   Policy # ______________________ Group # _____________________ Phone # ________________________
2. Does their insurance cover prescriptions? _____Yes _____No
3. Have you applied for Medicaid/MO HealthNet for Kids/IL All Kids? _____Yes _____No Date applied:________
   Medicaid/MO HealthNet for Kids/IL All Kids Information:
   Medicaid/MO HealthNet for Kids/IL All Kids #: _______________________________

INCOME

Total Annual/Yearly Household Income (gross income before taxes from **all** household members and **all sources**)

$_____________________Household Size _____________Source(s) of family income:_______________________

Please attach a copy of your household's current tax return and your latest pay stubs as proof of income. If you are unemployed, but receive government assistance of any type (ADC, SSI, WIC, etc), please send a copy of your card(s) or a letter from the Division of Family Services explaining your benefits. ***Your application cannot be processed without this information.***

(Over)

MEDICAL INFORMATION

1. Physician's Name: ______________________________ Phone: __________________
2. Pharmacy name, address, and phone number:______________________________

____

ASSISTANCE AND PROGRAM INFORMATION

Please mark the items you are asking for our assistance in obtaining:

Prescription Assistance Full Cost due to lack of insurance
Medications:____

Prescription Assistance Co-Pay due to high co-pays for medications
Medications:____

Spacer with Mask

Spacer without Mask

Nebulizer
Masks with Tubing Kit Pipe with Tubing Kit

Peak Flow Meter

Allergic bed encasings: Please indicate bed size: crib twin full queen king

REFERRAL INFORMATION:

How did you hear about *Project Concern* and the *Asthma & Allergy Foundation of America, St. Louis Chapter?*

From my child's physician
From the hospital nurse
From the social worker
From the school nurse
Other: ______________________________

VERIFICATION OF ACCURATE INFORMATION:

I verify that all the information provided on this application is accurate. I agree to notify AAFA of any changes in my financial status, address, phone number or if I no longer need assistance through *Project Concern*.

Parent/Guardian Initials_____________________date __________

I understand that I will be required to complete a renewal application/client questionnaire periodically to determine my child's (children's) continuing eligibility for assistance. If I do not return the completed renewal application and questionnaire, my child (children) will no longer be eligible to receive resources of any kind from the *Asthma and Allergy Foundation of America, St. Louis Chapter.*

Parent/Guardian Initials_____________________date __________

I understand that AAFA has permission to verify my status and/or provide my child/children's information to external sources such as Medicaid/MO HealthNet for Kids/IL All Kids, insurance, prescription assistance programs, Advocates for Family Health, etc.

Parent/Guardian Initials_____________________date __________

NOTICE OF PRIVACY PRACTICES:

HIPAA's Privacy Rule generally requires health care providers to require business associates to use appropriate safeguards to prevent the use or disclosure of PHI in a manner consistent with the Privacy Rule. AAFA safeguards your Protected Health Information (PHI). We may use your PHI to provide your child/children with health-related services, including the assistance you are requesting by completing and processing this application. The information may be used to coordinate care with pharmacies, with the health care and social service professionals involved in your child's health care including all PHI-related obligations of an outside health based agency that the Privacy Rule requires between a covered entity and a provider.

Parent/Guardian signature______________________________ Date:__________________

Referring health care professional signature:__________________________ Phone:_____________