



Asthma and Allergy Foundation of America®

ST. LOUIS CHAPTER

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www.aafastl.org

For Office Use Only:

Application received on: _____ by (initials) _____

Evaluation due date: _____

Approval Date: _____

CONFIDENTIAL

PROJECT CONCERN APPLICATION FOR ASSISTANCE

Please complete all the information on both sides of this application; we will not process incomplete applications.

Today's date: _____

PERSONAL DATA

Child's Name: _____ Date of Birth: _____

Phone Numbers

Home: _____ Cell: _____ Cell 2: _____ Work: _____

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

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Parent / Guardian Name _____

Relationship to Child: _____

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 (skip to #2)

If yes, check which of the following apply:

___ Private Insurance ___ Medicaid ___ MO HealthNet for Kids ___ IL All Kids

Insurance Information:

Name of Health Insurance Provider _____ Phone # _____

Policy # _____ Group # _____

RxGroup # _____ RxBIN# _____ PCN# _____

What is your deductible? _____ Have you met your deductible? _____

Does your insurance cover prescriptions? ___ Yes ___ No

If yes, what are your copay amounts? Brand: \$ _____ Generic: \$ _____

2. Have you applied for Medicaid/MO HealthNet for Kids/IL All Kids? ___ Yes ___ No Date applied: _____

What is your Medicaid/MO HealthNet for Kids/IL All Kids ID #: _____

INCOME

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

\$ _____ Household Size _____ Source(s) of family income: _____

Are you currently employed? If yes, where? _____

Please attach a copy of your household's current tax return and your latest 2 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 will not be processed without this information.

MEDICAL INFORMATION – Do you have a doctor/nurse who follows your child’s asthma?

1. Doctor/Nurse’s Name: _____ Phone: _____
2. School name and School nurse: _____

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 (please circle one: small or medium)
- Spacer without Mask
- Nebulizer
 - Masks with Tubing Kit Pipe with Tubing Kit
- Peak Flow Meter
- Allergy proof bed encasings: Please indicate bed size: crib twin full queen king pillow cases

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 school/hospital nurse (Hospital: _____ Nurse Name: _____)
- From the case/social worker (Case/Social Worker Name: _____)
- 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 Initials _____ date _____

Parent/Guardian signature _____ Date: _____

Referring health care professional name: _____

Referring health care professional signature: _____ Phone: _____