



HEMOPHILIA ASSISTANCE PROGRAM
 Texas Department of State Health Services
 P.O. Box 149347, MC 1938
 Austin, Texas 78714-9347
 (800) 222-3986

APPLICATION FOR ASSISTANCE
(Adults over 21)

1. Applicant Information

Applicant's Name: (Last, First, Middle)	Home Telephone:	()		
	Work Telephone:	()		
Permanent Mailing Address: (Street, P.O. Box, RFD)				
City:	Zip:	County:	State:	
Date of Birth: (month/day/year)	Resident of Texas? ____ Yes ____ No			
**Social Security #:	Sex: ____ Male ____ Female			

** The SSN is needed to coordinate hospitalization and medical benefits between HAP and other third-party payers such as an insurance policy, individual health plan, group health plan.

2. Members of Household

Name	Date of Birth	Relationship to Patient

3. Income Information

A. The following information is **required** of the patient and/or patient's spouse and/or any other person(s) legally obligated to provide for the patient:

Name	Relationship to Patient	Employer Name and Address	Gross Annual Income

B. Other sources of income available to the family or patient: (check yes or no on each item)

Type of Income	No	Yes	If Yes, Amount Received Each Month
Dividends			
Royalties			
Pensions/Retirement			
Social Security			
Social Security Disability			
Social Security Survivors			
Social Security Benefits			
Unemployment Compensation			
Rental Property			
Deferred Income			
Disability Income			
Other: Please Specify			

4. Insurance Information on Patient*

Is the patient insured: Yes No

If Yes, through whom? Patient Employer Spouse/Parent Employer Private Policy

Name of Insurance Company: _____

Address: _____

Telephone Number: _____

Policy Number: _____

Group Number: _____

Does insurance cover blood factor reimbursement? Yes No

If yes, what percentage does the insurance pay? _____

Effective Date: _____

Termination Date: _____

*Recipients eligible for coverage of allowable products under a private/group health insurance plan are not eligible to receive HAP benefits. A recipient who has exhausted this coverage may be eligible to receive benefits from HAP (Section 37.116 HAP Rules, Limitations and Benefits Provided).

5. Medicaid and Medicare*

A. Is patient covered by Medicaid? Yes No If Yes, Medicaid #: _____

Check other benefits being received: TANF Food Stamps Other

B. Is patient covered by Medicare? Yes No If Yes, Medicare #: _____

*Applicants who are eligible for Medicaid and/or Medicare are not eligible for the HAP program.

6. Applicant's Statement

I understand that this application is a legal document and that by signing I am stating from my personal knowledge that the facts in the application are true and correct. I understand that the application will not be accepted if it is incomplete.

I authorize release of medical information to the Texas Department of State Health Services as necessary to determine and maintain eligibility of the patient.

Signature of applicant/guardian: _____ Date: _____

7. Attach Verification Documents Here

Residency Verification – attach a copy of one of the following:

- valid Texas driver's license, or an identification card issued by the Texas Department of Public Safety;
- valid Texas voter's registration card, or a copy of a validated (at the county clerk's office) application or a voter's registration card;
- a current Texas motor vehicle registration or automobile license plate registration renewal form;
- a mortgage payment receipt from any of the three months immediately preceding the date of the application;
- a rent payment receipt from any of the three months immediately preceding the date of the application;
- a statement reflecting that the applicant is currently receiving rent-free housing. The statement must be signed by the individual providing the rent-free housing and must include the address and phone number of the individual providing the rent-free housing;
- a utility payment receipt from any of the three months immediately preceding the date of the application;
- a Texas property tax receipt for the most recently completed tax year;
- a payroll or retirement check dated within the three months immediately preceding the date of the application;
- employment/unemployment records prepared within the three months immediately preceding the date of the application;
- a statement from a financial institution issued within the three months preceding the date of the application; or
- Social security supplemental income or disability income records, or social security retirement benefit records issued within the three months immediately preceding the date of the application.

Income Verification – attach a copy of one of the following:

- employer's written verification of gross monthly income
- the most recent pay check stub/monthly employee earnings statement
- Internal Revenue Service (IRS) Income Tax Return forms for the most recently completed year
- pension/allotment award letters
- any other documents considered valid by HAP

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us/policy/privacy.shtm> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004.)

8. Medical Information

This section must be completed for all applicants to the Hemophilia Assistance Program and with every change in treating physician.

After completion, this form must be signed by a Texas licensed physician, **OR** a signed letter or medical report from a Texas licensed physician which contains the information may be substituted.

Applicant's Name:		Age:							
Name of Treating Physician:									
Address of Treating Physician:									
City:		State:							
Zip:									
Diagnosis:									
<input type="checkbox"/> Hemophilia	Usually Treated in:	Number of vials/units and type of blood products used during the last 12 months:							
<input type="checkbox"/> Hemophilia B									
<input type="checkbox"/> With Inhibitor		Vials/Units	#						
<input type="checkbox"/> Without Inhibitor		Type of Product							
<input type="checkbox"/> Other									
<table border="1"> <tr> <td rowspan="2">Where are blood products obtained?</td> <td>_____ Clinic</td> </tr> <tr> <td>_____ Emergency Room</td> </tr> <tr> <td rowspan="2">Average number of bleeding episodes during the last 12 months:</td> <td>_____ Hospital</td> </tr> <tr> <td>_____ Home</td> </tr> </table>				Where are blood products obtained?	_____ Clinic	_____ Emergency Room	Average number of bleeding episodes during the last 12 months:	_____ Hospital	_____ Home
Where are blood products obtained?	_____ Clinic								
	_____ Emergency Room								
Average number of bleeding episodes during the last 12 months:	_____ Hospital								
	_____ Home								
Date of last episode:									
Joints involved:									
Brief statement of anticipated treatment needs in coming year:									

Signature of Physician: _____

Date: _____