Patient Assistance Application

# Section 1: Patient information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last name | First name | | Middle name | | |
|  |  | |  | | |
| Gender | Date of birth | | Social security number | | |
|  |  | |  | | |
| E-Mail Address | | | | | |
|  | | | | | |
| Address line 1 | Address line 2 | City | | State | Postal Code |
|  |  |  | |  |  |
| Home phone | Cell phone | | Work phone | | |
|  |  | |  | | |
| Preferred contact phone | Residency Status | | | | |
| Home  Work  Cell  E-mail | U.S. Citizen Permanent U.S. Resident  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

**Complete Section 2 if you did not provide this information to NORD over the phone.**

# Section 2: Insurance and Provider Information

# Your insurance

I don’t have insurance.

I have insurance. My medication is covered under:  medical plan  drug plan

## Primary insurer

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Name of Insurance carrier* | | | *ID number* | | | | | | *Group number* | | |
|  | | |  | | | | | |  | | |
| *Type* | | | | | | | | | | | |
| Medicare  (Part A or B) | | Medicare  (Part D) | | | Employer-sponsored | | | COBRA | | | Private |
| *Deductible* | *Premium* | | | *Out-of-pocket maximum* | | | *Yearly cap* | | | *Co-pay/Co-insurance* | |
| $ | $ | | | $ | | $ | | | | $  % | |

# Your medication

|  |  |
| --- | --- |
| Diagnosis | Medication prescribed for the above diagnosis |
|  |  |

# Your doctor

|  |  |  |
| --- | --- | --- |
| Name | Specialty | Office contact (if known) |
|  |  |  |
| Phone number | Fax number | E-mail |
|  |  |  |

# Your pharmacy

|  |  |  |
| --- | --- | --- |
| Name | Phone Number | Fax Number |
|  |  |  |

# Section 3: Household Income

|  |  |
| --- | --- |
| Number of persons in household (family size) | Yearly household pre-tax income |
|  | $ |

If your income exceeds the income in the table below, you must also fill out section 4. The number of persons indicated as your “family size” should match your income tax forms.

These amounts constitute 400% of the Federal Poverty Line in effect as of 1/26/17 (aspe.hhs.gov/poverty-guidelines).

|  |  |
| --- | --- |
| Family size | Income |
| 1 | $48,240 |
| 2 | $64,960 |
| 3 | $81,680 |
| 4 | $98,400 |
| 5 | $115,120 |
| 6 | $131,840 |
| 7 | $148,560 |
| 8 | $165,280 |
| Each additional person | +$16,720 |

**Yes,** my income is at or below the corresponding amount on this table.

**Next Steps: Skip Section 4, and provide the 3 \*Required Financial Documents listed below**

**No,** my income is above the corresponding amount on this table.

**Next Steps: Complete Section 4, and provide the 3 \*Required Financial Documents listed below**

**\*Required Financial Documentation:**

|  |
| --- |
| 1. Your most recent tax return (with all pages attached) |
| 1. Your three most recent bank and investment account statements (all accounts) |
| 1. Copy of front and back of your insurance card, if applicable |

# Section 4: Total Assets, Liabilities, and Income

## Assets (total values, not monthly payments)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Checking accounts | Savings accounts | | Pension plans | | Securities and investments | | Primary residence | | Secondary residence |
| $ | $ | | $ | | $ | | $ | | $ |
| Value of vehicles | | Other asset name 1 | | Other asset value 1 | | Other asset name 2 | | Other asset value 2 | |
| $ | |  | | $ | |  | | $ | |

## Liabilities (total values, not monthly payments)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Due on mortgage | Total credit card debt | | Due on auto loans | | Home equity loans | | Student loans | | Past due child support |
| $ | $ | | $ | | $ | | $ | | $ |
| Past due taxes | | Other debt name 1 | | Other debt value 1 | | Other debt name 2 | | Other debt value 2 | |
| $ | |  | | $ | |  | | $ | |
|  | |  | |  | |  | |  | |

## Yearly Income (include income of anyone filing taxes jointly with applicant)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| W-2 Wages | Unemployment | Child Support | Social Security | Social Security Disability | **Total Adjusted Gross Income** |
| $ | $ | $ | $ | $ | $ |

## Monthly expenses

### Loan payments and property taxes (monthly payments, not total amount owed)

My property taxes are included in my mortgage.

|  |  |  |  |
| --- | --- | --- | --- |
| Mortgage payment/rent | Car payment | Property tax on home | Other property taxes |
| $ | $ | $ | $ |
| Auto loans | Home equity loans | Student loans | Other loans |
| $ | $ | $ | $ |

## Monthly expenses (continued)

### Utilities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Electricity | Heating | Garbage collection | Phone (home and cell) | Cable or satellite television |
| $ | $ | $ | $ | $ |
| Water | Transportation | Home maintenance | Internet service | Other utilities |
| $ | $ | $ | $ | $ |

### Insurance

My homeowner’s insurance is included in my mortgage.

My dental insurance is deducted from my paycheck.

My health insurance is deducted from my paycheck.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Life insurance | Dental insurance | Homeowner’s/renter’s insurance | Health insurance | Other insurance name | Other insurance cost |
| $ | $ | $ | $ |  | $ |

### Other

|  |  |  |  |
| --- | --- | --- | --- |
| Doctor’s visits  (including family) | Other medicines  (including family) | Alimony/child support (paid) | Garnishments and penalties |
| $ | $ | $ | $ |
| Other expense name | Other expense cost | Other expense name | Other expense cost |
|  | $ |  | $ |

Is there anything you would like us to know in consideration of your application?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please contact a NORD RareCare Patient Services Representative at 1-855-864-4027 or via email at chorea@rarediseases.org if you have any questions or require assistance with completing this form.

**This application, including the signed Disclosure and Authorization, may be returned to NORD via email, fax or U.S. Mail.**

Email to: chorea@rarediseases.org

Fax to: 1-203-635-4243

Mail to: National Organization for Rare Disorders

**Attn: Chorea Assistance**

55 Kenosia Avenue

Danbury, CT 06810

NORD processes applications on a first come first served basis. Funding is not guaranteed and so we urge you to return your completed application as soon as possible.

Disclosure and Authorization

**Identity**

I, the undersigned, am the patient, the patient’s parent or guardian, or otherwise legally authorized representative able to act on behalf of the patient.

**Application**

I certify that, to the best of my knowledge, all of the information provided in the application is complete and correct. I recognize that providing incomplete, inaccurate, or fraudulent information is grounds for revocation of my award.

Furthermore, I certify that I will notify the National Organization for Rare Disorders (hereafter referred to as NORD) of any changes to my treatment, diagnosis, or financial status.

I authorize my insurance company, prescribing physician, pharmacy, and/or listed contact person(s) to release to NORD any information that is needed or necessary to maintain my eligibility in the program. I authorize NORD to contact these entities to seek this information. I recognize that this information will be kept confidential and used for no other purpose than the enrollment process.

**Withdrawal**

I am aware that I may call NORD at any time at (800) 999-6673 to withdraw my application and revoke my permission to use my information.

**Awards**

I recognize that any award I may receive is subject to continued funding availability. I understand that NORD may withdraw my award or refuse payments for any reason at its discretion, with or without notice.

## Medicare

I recognize that any medical expenses paid by NORD and any services rendered by NORD may not be counted toward my Medicare True Out-of-Pocket (TROOP) expenditures.

**Medication**

I understand that NORD assumes no liability for the safety or efficacy of my medication or prescribed treatments. I agree to hold NORD harmless from any and all claims resulting from the use of my medication or treatments.

|  |  |  |
| --- | --- | --- |
| Patient Name | Name (if other than patient) | |
|  |  | |
| Signature *(when form is sent electronically your printed name indicates your intent to sign)* | Relationship to patient | Date |
|  |  |  |