State of Illinois
Department of Healthcare and Family Services

For Office Use Only
Identification
Patient Number

Application to the State Hemophilia Program

Please Complete Every Blank on this Application

Patient's Name (Mr., Mrs., Miss) _____ _____ _____
(First) (Middle) (Last)

Patient's Permanent Address _____
(Number, Street, Apartment, Rural Route, Box)

_____ _____ _____ _____
(City) (State) (Zip Code) (County)

Date of Birth _____ Social Security Number _____ Sex: Male ☐ Female ☐

Home Telephone Number _____ Work Telephone Number _____

Patient's Hemophilia Physician _____ Diagnosis _____

Name and Address of Hemophilia Treatment Center _____

_____

Members of Family Living in Household, Including Patient. List Head of Household First.		
Name	Age	Relationship to Patient

This State Agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83-99. Disclosure of this information is mandatory.

Public Assistance Case Number _____ Effective Date _____

☐ If the family is on Public Assistance, place an "X" in this square and do not complete the remainder of this application.

Major Medical Insurance and Prescription Drug Information	
Medical Insurance Company Name (Include Medicare)	Policyholder's Name and Policy Identification / Group Number
Prescription Drug Plan Name (If separate from Medical Ins.)	Policyholder's Name and Policy Identification / Group Number

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Does insurance (or drug plan) pay towards the cost of factor? ☐ Yes ☐ **No**

Other special information regarding your insurance &/or drug plan: _____

_____

EMPLOYMENT INFORMATION **Patient and Members of Family Living at Home Employed During the Past Year. If Patient is a Minor, Include Parent's or Guardian's Income.**				
Name	Employer	Income	Month or Annually	If Unemployed, State Last Day of Work

- **Please attach a Copy of your most recent State Income Tax Return (Form IL-1040).**
  <u>If patient is a minor, include parent's or guardian's State Income Tax Return.</u>

OTHER INCOME DURING THE PAST YEAR:

1. Unemployment Compensation $ _____ **x** _____ months, or $ _____ Total
2. Disability or Pension $ _____ **x** _____ months, or $ _____ Total
3. Social Security $ _____ **x** _____ months, or $ _____ Total
4. Other (specify) _____ $ _____ **x** _____ months, or $ _____ Total

I hereby certify that the answers given on this application and financial profile are correct and true to the best of my knowledge. I authorize the Illinois Hemophilia Program or its representatives to verify all facts herein stated relative to my financial condition or income. I consent to the furnishing by physicians or hospitals of any information requested by the Illinois Hemophilia Program regarding my diagnosis or treatment. A photocopy of this consent will be as valid as the original. It is understood that all information will be treated as confidential.

Signed _____ Date _____

(Patient signature - If minor, parent or guardian signature)

Please mail this application to:

Illinois Department of Healthcare & Family Services
Attn: Hemophilia Program
P. O. Box 19129
Springfield, IL 62794-9129

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(If Additional Space is Needed, Attach Extra Sheet of Paper)