www.kfaf.org
*Email: **sakina.bajowala@KFAF.org***

The mission of the Kaneland Food Allergy Foundation (KFAF) is to improve awareness of and access to evidence-based, life-changing treatment for patients with food allergies, through educational initiatives, community outreach, and financial assistance.

PATIENT FINANCIAL ASSISTANCE APPLICATION

This Patient Financial Assistance Application will be used to evaluate your eligibility for financial assistance for food allergen desensitization treatment only. To ensure prompt and fair review of your application, please complete all sections. **Do not leave blanks.** Your application must include all required documents to confirm/verify your identity, residency, citizenship status, employment, family source(s) of income, and insurance coverage/eligibility. You must also submit a duly completed and signed "Statement of Medical Necessity for Food Allergen Desensitization" (last 2 pages of this application) from your Board-Certified allergist. KFAF may request additional documents, if necessary, to complete your application. KFAF will notify you of its decision within 90 business days from the date of receipt of your completed application and documentation.

Please send your completed, signed application and all required supporting documents to:

Kaneland Food Allergy Foundation
Patient Financial Assistance Application
1213 Oak Street
North Aurora, IL 60542

If your application for financial assistance for food allergen desensitization treatment is approved, no part of the assistance award will be paid directly to you. KFAF will issue a check on your behalf directly to your designated allergist to cover a portion of non-reimbursable charges / expenses related to the patient's food allergen desensitization treatment. This payment will be made as the final payment on your balance with your allergist's office once the prescribed treatment course is complete. Please note: Your financial assistance will be forfeited if you elect to discontinue food allergen desensitization without a medical cause.

PATIENT FINANCIAL ASSISTANCE APPLICATION

Application Date: _____

I. Patient Information:

Full Name: _____

Street Address: _____

City: _____ County: _____

State and Zip Code: _____ Telephone #: _____

E-mail Address: _____

Date of Birth: _____ Sex: _____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____

Citizenship Status: U.S. Citizen ____ Permanent Resident ____ Student Visa ____

Other (Please explain) _____

If Minor (<18 years), Parent/Guardian Information:

Full Name: _____

Patient Relationship: _____ Telephone #: _____

E-mail Address: _____

Date of Birth: _____ Sex: _____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____

Citizenship Status: U.S. Citizen ____ Permanent Resident ____ Student ____

Other (Please explain) _____

If current primary residence address mentioned above is less than one year old, please provide the following previous address information:

Street Address: _____

City: _____ County: _____

State and Zip Code: _____ Telephone #: _____

II. Medical / Health Insurance Information:

Is patient covered by medical / health insurance? Yes ____ No ____

If "Yes", Name of the Insurance Provider: _____

Phone number of Insurance Provider: _____

Name of Insured Individual: _____

Insurance Group Number: _____

Member ID Number: _____

III. Employment Status Information:

What is the employment status of patient (or parent/guardian, if applicable)?

Employed: _____ (Date of Hire / Self-Employment: _____)

Unemployed: _____ (Date of Last Employment: _____)

Retired: _____ (Date of Retirement: _____)

Other: _____ (Please Explain: _____)

Employer's Name: _____

Employer's Address: _____

_____

Supervisor's Name: _____ Telephone #: _____

Job Title: _____ Salary: $_____ / ____

IV. Treating Physician's Information:

Name of Allergist: _____

Allergist's Address: _____

_____

Allergist's Telephone #: _____ Fax #: _____

V. Patient Family Information:

Please list everyone the patient (or parent/guardian) is legally responsible for, including spouse and dependents.

Name:	_____	_____	_____
Relationship to Patient:	_____	_____	_____
Age:	_____	_____	_____
Family Income Contributor?	Yes / No	Yes / No	Yes / No

Please list everyone who is legally responsible for the financial support of the patient (or parent/guardian), including those who claim him/her as a dependent or tax credit.

Name:	_____	_____	_____
Relationship to Patient:	_____	_____	_____
Age:	_____	_____	_____
Family Income Contributor?	Yes / No	Yes / No	Yes / No

VI. Patient Family Income and Expenses Information:

All adult family members' income must be disclosed. Proof must be provided for every identified source of income, as income verification is required to determine financial assistance. Examples of proof of income include:

- U.S. Individual Income Tax Return (Form 1040, 1040EZ, etc.) with W-2 and all Schedules and attachments for the most recent year
- Social Security Earnings Statement or the latest Social Security Award Letter
- Most recent Disability Earnings Statement
- Unemployment Compensation records
- Written statements from employers and/or welfare agencies

Monthly Household Expenses:

Rent / Mortgage:	$_____	Medical Expenses:	$_____
Insurance Premium:	$_____	Utilities:	$_____
Food / Clothing:	$_____	Other Debt / Loans:	$_____
Vehicle/Transport	$_____	Tuition/Childcare:	$_____

VII. Authorization for Disclosure of Health Information:

I, the undersigned, hereby authorize my allergist _____
to disclose or release the following information from the health records of patient (see below) to help Kaneland Food Allergy Foundation (KFAF) evaluate my financial assistance application for the said patient's food allergen desensitization treatment.

Patient Name: _____

Patient Address: _____

_____

Telephone #: _____ Date of Birth: _____

Patient ID / Number: _____

This authorization will cover all periods of food allergy treatment.

Food allergy treatment Information to be disclosed or released:

- Progress Notes (pertaining to food allergy diagnosis)
- Allergy Test Results (Skin Test and Laboratory)
- Statement of Medical Necessity for food allergen desensitization (see attached form)
- Demographic Records
- Financial Records (Total Fees / Charges, and Outstanding Payment Amount)
- Insurance Coverage/Benefits/Eligibility Details
- Insurance / Medicaid / State / County Reimbursement Records

This information to be disclosed or released to:

Kaneland Food Allergy Foundation
1213 Oak Street
North Aurora, Illinois 60542

This authorization can be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will remain in effect for the duration of two years from the date of its execution signing. It is further understood that patient's food allergy treatment by the allergist mentioned above will not be affected if I decide not to sign this authorization. However, it will automatically empower KFAF to remove my application for financial assistance from further consideration/evaluation.

Signed: _____ Date: _____
(Patient or Parent / Guardian)

VIII. Supporting Documents Requirement Information:

The following supporting documents are required to enable KFAF's verification of the information provided in your Patient Financial Assistance Application (Please put an "X" for each specific document included with your application):

*Proof of Identity (Any **One** of the following)*:

___ Copy of your (or Parents'/Guardian's) currently valid Driver's License
___ Copy of your (or Parents'/Guardian's) currently valid Government-issued Photo Identification Card

*Proof of Primary Residence (Any **two** of the following)*:

___ Copies of Utility bills in your (or Parents'/Guardian's) name at least for the past six months
___ Copy of the currently valid Voter Registration Card
___ Copies of bank statements/cancelled checks at least for the past six months
___ Copy of the deed or the most recent property tax statement or receipt
___ Copy of the currently valid Home Insurance Policy

*Proof of Citizenship/Permanent Resident Status (Any **one** of the following)*:

___ Copy of your (or Parents'/Guardian's) currently valid U.S. Passport
___ Copy of your (or Parents'/Guardian's) Alien Registration Card
___ Copy of your U.S. Birth Certificate
___ Copy of your (or Parents'/Guardian's) Certificate of Naturalization

*Proof of Family Income (**All** that apply of the following)*:

___ Copy of the most recently filed U.S. Individual Income Tax Return with all Schedules and attachments for the most recent year
___ Copy of IRS Statement of Non-Filing if U.S. Individual Tax Return for the most recent year is not completed
___ Social Security Earnings Statement or the most recent Social Security Award Letter
___ Copies of Unemployment Compensation payments for the past 12 months
___ Copy of the most recent Disability Earnings Statement
___ Copies of the most recent income statements from IRAs, pensions, annuities, or any other source for the past 12 months, if not reported on your (or Parents'/Guardian's) U.S. Individual Tax Return
___ Documentation of all other income for the past 12 months not listed above

IX. Applicant Agreement / Certification:

I understand that this Patient Financial Assistance Application may not be processed until all required information, including supporting documentation, is submitted. I understand that additional information may be required to process my application.

I certify that the information provided in this application is true, complete, and accurate to the best of my knowledge. I agree to notify Kaneland Food Allergy Foundation (KFAF) of any change in my insurance eligibility or financial status. I authorize KFAF to verify all submitted information in my application.

I will independently (or with assistance from my allergist) apply for ANY and ALL financial assistance which may be available through Federal, State, County, or Local Government and private sources, to help pay for my outstanding fees/charges/expenses/obligations related to the said patient's food allergen desensitization treatment.

I understand that if any information that I have submitted in my application is found to be inaccurate, false, incomplete, or misleading, any financial assistance that may have been approved or already provided by KFAF will be rescinded and/or fully returned.

Applicant Signature: _____

Applicant Name: _____

Patient Name (If not same): _____

Relationship to Patient: _____

Date Application Signed: _____

Statement of Medical Necessity for Food Allergen Desensitization, Page 1/2

Please complete all sections. Page 1 may be completed by patient/guardian but should be reviewed by allergist prior to submission. Page 2 to be completed by prescribing/supervising allergist.

Patient Information:

Full Name: _____

Date of Birth: _____ Sex: _____

Food Allergy History:

Food allergen	Date of initial reaction	Symptoms	Date of most recent exposure	Symptoms	SPT result / date	sIgE / date	OFC result / date

Completed by: _____ Date: _____

Reviewed by: _____MD/DO Date: _____

Statement of Medical Necessity for Food Allergen Desensitization, Page 2/2

Recommended Treatment(s):

Epicutaneous immunotherapy (EPIT) for: _____

Start date: _____ Anticipated date of completion: _____

Estimated Charges: _____ Estimated Patient OOP Expense: _____

Sublingual immunotherapy (SLIT) for: _____

Start date: _____ Anticipated date of completion: _____

Estimated Charges: _____ Estimated Patient OOP Expense: _____

Oral Immunotherapy (OIT) for: _____

Start date: _____ Anticipated date of completion: _____

Estimated Charges: _____ Estimated Patient OOP Expense: _____

Supervising Allergist/Immunologist:

Name: _____

NPI: _____ Email: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

_____

Signature of MD/DO Date