STATE HEMOPHILIA PROGRAM (SHP) FINANCIAL INVENTORY

DO YOU WISH TO APPLY FOR BENEFITS FROM THE STATE HEMOPHILIA PROGRAM? ☐ YES ☐ NO

IF ANSWERED "NO" DISREGARD THIS FORM. IF "YES" PLEASE PROVIDE ALL INFORMATION REQUESTED AND COMPLETE BOTH SIDES OF THIS FORM.

Patient Name ______________________________
Last *First* *Middle*

Address ______________________________

City/State ____________ Zip ________ County ____________

Telephone ( ) ____________ Date of Birth ____________

Social Security Number ____________ Race ________ Sex ________

E-Mail Address (if applicable) ____________

Insurance	yes	no	Policy Number	Eff Date
Medicare				
Private Ins				
TennCare				
Dental Ins.				

If you have no insurance coverage, have you applied for TennCare? ☐ YES ☐ NO Date Applied ________

Patient Diagnosis ____________ ☐ Mild ☐ Moderate ☐ Severe

Hemophilia Clinic: ☐ TC THOMPSON ☐ ETSU ☐ UT KNOXVILLE ☐ UT MEMPHIS ☐ VANDERBILT

GROSS MONTHLY INCOME $ ________ ** **(must attach copy of most recent Tax Return)**

☐ Check if not required to file tax return

If no tax return is filed, what is the source of your income?
☐ Social Security ☐ Disability ☐ SSI ☐ Other ________

Other monthly income: $ ________
(child support, rental income, pensions, benefits, interest, dividends, public assistance)

Monthly Insurance Premiums $ ________

Monthly Medical Payments $ ________

Monthly Child Support Paid to Another Household $ ________

FOR SHP USE ONLY

Adjusted Gross ________

SHP Allowed ________

Family Size ________

( ) Approved ( ) Denied

SHP Staff ________

Review Date ________

I certify that the above information is correct to the best of my knowledge and understand that the State Hemophilia Program (SHP) may request documentation of any or all information provided on this form.

Signature ______________________________ Date ____________
(Patient/Parent/Guardian)

Rev 10/03

(Complete BACK SIDE of Form)

SHP FINANCIAL INVENTORY (Continued)

Employment Information: If patient applying for assistance from the SHP is under 18 years of age, is a school-age dependent or a disabled dependent, employment information must be provided for the legal parent or guardian. **All family income must be reported.**

Employer ______________________________

Address ______________________ City ______________________

State ________ Zip ________ Phone ______________________

Employer ______________________________

Address ______________________ City ______________________

State ________ Zip ________ Phone ______________________

Family Members: Please list all family members living in home with applicant.

Name	*Social Security No.*	*Relationship*	*Birthdate*	*Bleeding Disorder*

Explanation of requested information:

Gross Income - Total income before taxes. The following must be included as income: wages, salaries and/or commissions; income from rental property or equipment; profits from self-employment enterprises, including farms; alimony and/or child support; pensions and benefits; interest and dividends (not face value); public assistance (social security, disability, food stamps, etc.)

Insurance Premiums - The amount listed **must** be the premium amount paid directly by the applicant, applicant's legal parent or guardian. (If the employer is paying part or all of the premium, do not list the amount paid by the employer.) List only that amount paid by the applicant or applicant's family.

Medical Payments - Only **actual payments being made** on medical bills may be counted. **DO NOT** include payments made on health insurance premiums as insurance is counted separately.