STATE HEMOPHILIA PROGRAM
TENNESSEE DEPARTMENT OF HEALTH
7TH FLOOR ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243
PHONE: (615) 741-0405
FAX: (615) 532-2785
Email: carolyn.woodard@tn.gov

Please Read Carefully and Follow These Instructions to make sure
All information required is sent in at the same time.

IMPORTANT: COMPLETE ALL INFORMATION ON BOTH SIDES OF THE FINANCIAL FORM AND INCLUDE THE REQUESTED DOCUMENTS WHEN FORM IS RETURNED TO THE SHP OFFICE. INCOMPLETE FINANCIAL FORMS CANNOT BE PROCESSED AND CONTINUATION OF PATIENT BENEFITS MAY BE DELAYED UNTIL ALL INFORMATION IS PROVIDED.

- The financial inventory must be completed in the name of the individual who wishes to receive assistance from the State Hemophilia Program. If the applicant is under 18 years of age, is a school-age dependent, or a disabled dependent, the financial form **must** be completed by the applicant's legal parent or guardian.

- **INCOME: Must attach copy of most recent Tax Return or Other Proof of Income ****
  If income tax are not required to be filed, please submit other documentation such as social security, disability, unemployment, SSI or child support check stubs, or approval letters such as food stamps, etc., showing the approved amounts to be received each month. If you **do not have any source of income**, then the SHP requests that you explain your situation in a notarized letter.

- **TOTAL HOUSEHOLD INCOME must be reported.**
  You and Anyone 21 years of age and older living in your home must provide current proof of income with the financial form.

- **Monthly Health Insurance Premiums & Monthly Medical Payments**
  Any verified health insurance premiums or medical payments (out of pocket medical expenses) made by the family for any family member during the previous twelve (12) months shall be prorated over twelve months and deducted from the gross monthly income.

- Applicants accepted for TennCare coverage must meet all TennCare requirements in order to remain eligible for the State Hemophilia Program (SHP).

- **All SHP participants** must be financially certified **Annually.** Financial certification extends for one year, regardless of changes in family income.

- **SHP participants are required to have a comprehensive medical evaluation** at one of the four Comprehensive Hemophilia Centers contracting with the SHP on a regular schedule to be determined by the Center staff. **Failure to receive regular comprehensive evaluations may result in termination from the SHP.**

If you have questions regarding how to complete the financial inventory form, please contact the nurse or social worker at your clinic, or you may call Carolyn Woodard, Hemophilia Program Administrator, at (615) 741-0405.

Updated 2/2/2023

STATE OF TN 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 ☒ MEMPHIS ☐ VANDERBILT

GROSS MONTHLY INCOME $ _____ ** **(Must Attach PROOF of INCOME)**

☐ 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 Health Insurance Premiums $ _____

Monthly Out-of Pocket Medical Expenses $ _____

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 4/15

(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.

Out-of Pocket Medical Espenses - Only **actual out-of-pocket payments being made** on medical expenses may be counted. DO NOT include payments made on health insurance premiums as insurance is counted separately.

AUTHORIZATION FOR RELEASE OF MEDICAL AND FINANCIAL INFORMATION

TN STATE HEMOPHILIA PROGRAM

I, THE UNDERSIGNED, DO AGREE TO AUTHORIZE THE RELEASE OF ALL PREVIOUS MEDICAL RECORDS TO THE TENNESSEE DEPARTMENT OF HEALTH AND AUTHORIZE THE DEPARTMENT TO RELEASE SUCH RECORDS AS MAY BE NECESSARY. I ALSO AUTHORIZE THE DEPARTMENT TO REVIEW MY FINANCIAL RECORDS AT ANY INSTITUTION, AGENCY, CORPORATION OR ANY OTHER ESTABLISHMENT WHICH HAS OR MIGHT HAVE KNOWLEDGE OF MY FINANCIAL ASSETS OR CIRCUMSTANCE DURING THE APPLICATION PROCEDURE AND WHILE PARTICIPATING IN THE PROGRAM.

FURTHER, IF ACCEPTED, IT IS UNDERSTOOD THAT THE PROGRAM COVERS ONLY THOSE COSTS FOR HEMOPHILIA AND THAT COSTS FOR OTHER ILLNESSES WILL NOT BE COVERED. PAYMENT FOR SPECIFIED CARE WILL BE PROVIDED AS LONG AS CURRENT APPROPRIATIONS ARE AVAILABLE OR UNTIL THE END OF THE FISCAL YEAR IN WHICH THIS APPLICATION WAS MADE. I DO FURTHER UNDERSTAND THAT THIS FORM WILL NOT HAVE TO BE REVIEWED EACH YEAR AND WILL REMAIN IN FORCE ACCORDING TO THE CONDITIONS ABOVE AND IN ACCORDANCE WITH THE POLICIES DEVELOPED BY THE TENNESSEE DEPARTMENT OF HEALTH.

_____
(Applicant's Signature)

_____
(Parent or Guardian's Signature)
if under 18

_____ _____
(Witnessed by) (Date)

_____
(Title and/or Address)

shpauth.doc