BREATH
Bridging Resources to Encourage Asthma Treatment & Health

CONFIDENTIAL

BREATH® Application

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Directions:

1. Complete all the information on both sides of this application; AND complete the survey (page 3)
2. Enclose proof of income a copy of your household's current tax return and your 2 most recent pay stubs. If you are unemployed, but receive government assistance of any type (ADC, SSI, WIC, etc.), please send a copy of your benefits statement.
3. Mail/Fax to The Asthma and Allergy Foundation of America - STL, 1500 South Big Bend Suite 1S, St. Louis, MO 63117. Phone: (314) 645-2422, Fax: (314) 645-2022 Website: www.aafastl.org

We will not process incomplete applications

PERSONAL DATA

Today's Date: _____

Child's Name: _____ Date of Birth: _____

My child has been diagnosed with (check all that apply): ☐ Asthma ☐ Exercise-induced asthma ☐ Eosinophilic Esophagitis (EoE) ☐ Eczema ☐ Allergies ☐ Food Allergies

For Statistical Purposes Only:

☐ Male ☐ Female

☐ African-American ☐ Asian-American ☐ Caucasian ☐ Hispanic/Latino ☐ Native American/Alaska Native

☐ Bi/Multi-Racial ☐ Hawaiian/Pacific Islander ☐ Other _____

Contact Information

Parent/Guardian Name _____

Address _____

City _____ State _____ Zip _____ County _____

Cell _____ Home _____ Work _____ Cell 2 _____

Email (will be used for *BREATH* communications only) _____

Best method of contact to reach you? ☐ Home Number ☐ Cell Number ☐ Work Number ☐ Text ☐ Email

Parent/ Guardian Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Other: _____

I am willing to share our story about managing asthma and/or allergies with AAFA and our donors ☐ Yes ☐ No

HEALTH COVERAGE INFORMATION

1. Is your child covered by any kind of health coverage or insurance? ☐ Yes ☐ No (If no, skip to question #2)

   If yes, check which of the following apply

   ☐ Private Insurance ☐ Medicaid ☐ MO HealthNet for Kids ☐ IL All Kids

   Insurance Information

   Name of Health Insurance Provider _____ Phone Number _____

   Policy# _____ Group# _____

   RxGroup# _____ RxBIN# _____ PCN# _____

   What is your deductible? $_____ Have you met your deductible? ☐ Yes ☐ No ☐ Don't Know

   Does your insurance cover prescriptions? ☐ Yes ☐ No

   If yes, what are your co-pay amounts? Brand $_____ Generic $_____

2. Have you applied for Medicaid/MO HealthNet for Kids/IL All Kids? ☐ Yes ☐ No Date Applied _____

What is your Medicaid/MO HealthNet for Kids/All Kids ID #

INCOME

Total Yearly Income (gross income before taxes from **all** household members and **all sources**)

$_____ Household Size _____ Source(s) of Family Income _____

Are you currently employed? If yes, where? _____

MEDICAL INFORMATION

Do you have a doctor/nurse who follows your child's asthma/allergies?

1. Doctor/Nurse's Name _____ Phone _____
2. School Name _____ School Nurse _____
3. Name of Pharmacy that currently has your prescriptions _____
4. List of medications prescribed for your child's asthma/allergies _____

_____

ASSISTANCE REQUESTS

Please check the boxes next to what you need

Prescription Assistance

- □ *Full-Pay* due to lack of insurance **OR**
- □ *Co-Pay* due to high co-pays for medications

Medical Durable Equipment

- □ Spacer with Mask (please circle one: small mask, medium mask) **OR** □ Spacer without Mask
- □ Nebulizer Machine
- □ Nebulizer Masks with Tubing Kits **OR** □ Nebulizer Pipe with Tubing Kit
- □ Peak Flow Meter

Bed Encasings

- □ Allergy proof bed encasings, please indicate size: □ Crib □ Twin □ Full □ Queen □ King □ Pillow Case

REFERRAL INFORMATION

How did you hear about *BREATH* and the *Asthma & Allergy Foundation of America, St. Louis Chapter*?

- □ From my child's physician
- □ From the school/hospital nurse (Hospital _____ Nurse Name _____)
- □ From a Case/Social Worker (Please provide their name: _____)
- □ Other: _____

VERIFICATION OF ACCURATE INFORMATION (Please Read Carefully)

I verify that all the information provided on this application is accurate. I agree to notify AAFA of any changes in my financial status, address, phone number or if I no longer need assistance through *BREATH.*

Parent/Guardian Initials _____ Date _____

I understand that I will be required to complete a renewal application/client questionnaire periodically to determine my child's (children's) continuing eligibility for assistance. If I do not return the completed renewal application and questionnaire, my child (children) will no longer be eligible to receive resources of any kind from the *Asthma and Allergy Foundation of America, St. Louis Chapter.*

Parent/Guardian Initials _____ Date _____

I understand that AAFA has permission to verify my status and/or provide my child/children's information to external sources such as Medicaid/MO HealthNet for Kids/IL All Kids, insurance, prescription assistance programs, Advocates for Family Health, Southeast Missouri's Center for Environmental Analysis, Epharmix Mobile Health (providers covered under free plan: AT&T, T-Mobile/MetroPCS,Verizon Wireless, Sprint/Virgin/Boost), etc.

Parent/Guardian Initials _____ Date _____

NOTICE OF PRIVACY PRACTICES

HIPAA's Privacy Rule generally requires health care providers to require business associates to use appropriate safeguards to prevent the use or disclosure of PHI in a manner consistent with the Privacy Rule. AAFA safeguards your Protected Health Information (PHI). We may use your PHI to provide your child/children with health-related services, including the assistance you are requesting by completing and processing this application. The information may be used to coordinate care with pharmacies, with the health care and social service professionals involved in your child's health care including all PHI-related obligations of an outside health based agency that the Privacy Rule requires between a covered entity and a provider.

Parent/Guardian Initials _____ Date _____

Parent/Guardian Signature _____

PATIENT ADVOCATE

- □ I am applying on behalf of the patient and I have his/her approval; I have read and understand the requirements of a patient advocate

Patient Advocate Name: _____

Patient Advocate Signature: _____ Phone _____

Asthma Control Test Survey

** if we do not receive this survey within your application, we will not process your application.**

Child's Name _____ Date of Birth _____

1. In the past 4 weeks, how much of the time did you/your child's asthma keep them from getting as much done at work, school or home?

   □ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

2. During the past 4 weeks how often has you/your child had shortness of breath?

   □ More than once a day □ Once a day □ 3-6 times a week □ Once or twice a week □ Not at all

3. During the past 4 weeks, how often did you/your child's asthma symptoms wake them up at night or earlier than usual in the morning?

   □ 4 or more nights a week □ 2 or 3 nights a week □ Once a week □ Once or twice □ Not at all

4. During the past 4 weeks, how often has you/your child used their rescue inhaler or nebulizer medication (such as Albuterol)?

   □ 3 or more times per day □ 1 or 2 times per day □ 2 or 3 times per week □ Once a week □ Not at all

5. How would you rate your/your child's asthma control during the past 4 weeks?

   □ Not controlled at all □ Poorly controlled □ Somewhat controlled □ Well controlled □ Completely controlled

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6. In the past 4 weeks I/my child has visited an emergency room _____ times due to asthma/allergies.
   □ 0 □ 1 □ 2 □ 3 □ 4 □ _____
7. In the past 4 weeks I/my child has spent _____ nights in the hospital due to asthma/allergies.
   □ 0 □ 1 □ 2 □ 3 □ 4 □ _____
8. In the past 4 weeks, how often did you/your child's asthma (check all that apply):
   1. Kept them from going to school? # Days missed: □ 0 □ 1 □ 2 □ 3 □ 4 □ _____
   2. Prevented you (the parent) from going to work? # Days missed: □ 0 □ 1 □ 2 □ 3 □ 4 □ _____
9. In the past 4 weeks, I have filled the medicines AAFA helps provide □ Yes □ No □ N/A
   If yes, what medicine did you fill? _____
10. In the past 4 weeks, has your child/you been taking medicines AAFA helps provide? □ Yes □ No □ N/A
    If yes, which medicine? _____

For Official Use Only:
X_____Initial with Application