HFM/CASCADE DENTAL PLAN APPLICATION

➢ **ADULT APPLICANT (age 18 and over)**

SECTION 1: INSTRUCTIONS

1. This form is for use by adults wishing to apply for Delta Dental benefits through the HFM/Cascade Dental Plan.
2. Answer all questions completely. Incomplete applications will delay the eligibility determination process.
3. Sign and date the completed application.
4. Review the "checklist" (section 8) at the end of this application to ensure you have provided all of the required information for Hemophilia Foundation of Michigan to review and process your application.

SECTION 2: APPLICANT INFORMATION

Social Security No.:_____

Name: _____ Date of Birth: _____ Age: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female County of Residence: _____

Home Phone Number: _____ Cell Phone Number_____

Email Address: _____

Marital Status:_____

SECTION 3: ENROLLMENT INFORMATION

1. Are you a resident of the state of Michigan? …… ☐ Yes ☐ No
2. Are you eligible for dental insurance through your employer?..... ☐ Yes ☐ No
3. Are you eligible for dental insurance through your spouse's employer?..... ☐ Yes ☐ No
4. If your employer or your spouse/partner's employer offers dental insurance, why are you not covered under that dental plan?

   _____
5. If you are under the age of 26, are you eligible for dental insurance through a parent's employer? ☐ Yes ☐ No
6. If you are eligible under your parent's plan, why are you not covered under that plan?

   _____
7. Do you have coverage under Medicaid or CSHCS? ….. ☐ Yes ☐ No ID#:_____
8. Do you have Medicare? ☐ Yes ☐ No Medicare # _____
9. If so, do you have a Medicare Advantage Plan? ……..…….. ☐ Yes ☐ No

10. If so, does your Medicare Advantage Plan have dental coverage? ……..…..... ☐ Yes ☐ No
11. Are you covered under any other dental plan?..... ☐ Yes ☐ No
12. Do you have any special circumstances that need to be considered in this application?
    Please note that exceptions for special circumstances will be done on a case by case/yearly renewal basis in coordination with your HTC Social Worker or Nurse.
    ☐ Access issue
    ☐ Extensive dental work in the coming year
    ☐ You have Medicaid coverage but your dental work will be in excess of your benefits
    ☐ Other

    _____
13. How many immediate family members including yourself are living in your home?_____

SECTION 4: INFORMATION ABOUT YOUR BLEEDING DISORDER

1. Have you been diagnosed with a bleeding disorder? ……..…… ☐ Yes ☐ No
2. Do you receive your medical care at a Hemophilia Treatment Center (HTC) ? .. ☐ Yes ☐ No

If yes, at which HTC do you receive treatment?_____
If no, what is the name of your Hematologist? _____

SECTION 5: EMPLOYMENT INFORMATION

1. Applicant's Employment Status: ☐FullTime ☐PartTime☐ SelfEmployed ☐ Unemployed ☐ Retired
2. Spouse/Partner Employment Status:☐FullTime☐PartTime ☐SelfEmployed ☐Unemployed ☐Retired
3. Are you claimed as a dependent on anyone else's income tax return? (such as a parent, stepparent) ……..……..☐ Yes ☐ No
   a. If yes, name of person(s) who claimed you:_____
   b. Relationship to you? _____
   c. Employment status of person(s) who claimed you:
      ☐ Employed FullTime ☐ Employed PartTime ☐ SelfEmployed ☐ Unemployed ☐ Retired

NOTE: You must provide verification of income for each person listed here. See Checklist in Section 8 for acceptable types of verification.

SECTION 6: SLIDING FEE SCHEDULE—ANNUAL INCOME

- **The total cost of each policy through the HFM/Cascade Dental Plan is currently $823 per year.**
- **You may be asked to pay a portion of this cost based on your annual household income. Please use the chart below to estimate your portion of the Annual Premium.**
- **HFM will review the income verification documents you provide with this application to make a final determination of your portion of the Annual Premium.**

Individual Income	Family of 2	Family of 3	Family of 4	Family of 5	Applicant Portion of Annual Premium
0 - **$**22,000	0 – $30,000	0 – $37,000	0 – $45,000	0 – $52,000	**0**
22,001-**32,000**	30,001-50,000	37,001-57,000	45,001-65,000	52,001-72,000	$50.00 per year
32,001-60,000	50,001-70,000	57,001-77,000	65,001-85,000	72,001-92,000	$100.00 per year
60,001 +	70,001 +	77,001 +	85,001 +	92,001 +	$150.00 per year

SECTION 7: VERIFYING YOUR UNDERSTANDING OF THIS APPLICATION

1. I understand that the HFM/Cascade Dental Plan can only accept a limited number of applicants and that priority will be given to applicants based on their resources to access dental care. I understand that I may be placed on a waiting list if there are not spaces available when my application is received.
2. I understand that until HFM approves my application and I pay my Annual Premium cost (if any) no coverage will be effective.
3. I understand that I am subject to disenrollment and exclusion from this program if the information I provided is false, fraudulent or contains intentional misrepresentation of facts.
4. I understand that it is my responsibility to inform HFM of any changes that may affect my eligibility, including any dental insurance that I may obtain in the future.
5. I understand that if I move out of the state of Michigan, I must notify HFM so that I can be dis-enrolled.
6. I understand that annual reenrollment is necessary in order to remain on this program. I understand that if I do not complete the annual reenrollment process and pay my Annual Premium cost (if any), I will be dis-enrolled from this program.
7. I understand that if I voluntarily dis-enroll or if I am involuntarily dis-enrolled from the HFM/Cascade Dental Plan, I may not reapply for at least one year after my coverage ends.
8. I understand that my identifying information will be shared with Cascade Hemophilia Consortium for the purposes of verifying my dental benefits and for processing dental premium payments. I understand that my identifying information will NOT be used for marketing of any other services Cascade provides.
9. I understand that, by signing below, I certify that all information and documents provided as a part of this application are complete, accurate and true to the best of my knowledge and belief.

_____ _____

Applicant Signature Date

SECTION 8: CHECKLIST FOR SUBMITTING YOUR APPLICATION

Please Note: If this is an application renewal only – you only have to provide verification of Michigan residency and income. We have the other two items on file from your original application.

❒ **Verification of Michigan Residency (for the parent/guardian applying completing this application)**

- Attach copy of MI Driver's License or MI State Identification Card OR
- Copies of 2 recent utility bills, in your name, that show your address (within last 3 months)

❒ **Verification of ALL Income (for each household member)**

- 2 pay stubs (no older than 3 months old) OR
- A copy of your tax return from last year
- Proof of Unemployment Benefits
- Social Security Disability
- Proof of Retirement Income

❒ **Verification of Bleeding Disorder**

- Attach letter from your Hemophilia Treatment Center or treating Hematologist verifying that your child has been diagnosed with a bleeding disorder. A copy of your Annual Comprehensive Visit report will also be accepted.

❒ **Release of Information Forms (2) (see next pages for forms)**

❒ **Please mail or fax this application with all required documentation to:**

- **Hemophilia Foundation of MI, 1921 W. Michigan Ave, Ypsilanti, MI 48197**
- **Phone: 734-544-0015**
- **Fax: 734-544-0095**

If you have any questions about the Delta Dental Program please contact Lisa Clothier, Outreach and Community Education Manager at 734-961-3512.

HFM/Cascade Dental Program
Participant Acknowledgement of Responsibilities Form

Participant Name: _____ **Date:** _____

Thank you for your interest in enrolling in this program for dental coverage. The Hemophilia Foundation of Michigan and Cascade Hemophilia Consortium are pleased to be able to provide this program to you. We want to ensure that you fully understand the coverage provided and the limitations.

Please read and initial the following:

_____ I understand that I must complete all necessary initial enrollment application and forms, including annual renewal forms and provide verification of income in order to participate in the program.

_____ I understand that I must attend **at least two preventative dental visits each year** to utilize this program.

_____ I agree to call Delta Dental or utilize the Delta Dental Consumer Toolkit that is available on the internet to verify my annual benefit that is still available.

_____ I understand that I am responsible to insure that my dentist is a covered **IN NETWORK** provider and to request a **Pre-Treatment Estimate** so that I will understand what procedures are covered and what cost I would be responsible for **BEFORE** I receive treatment.

_____ I understand that I have a maximum **Annual** benefit limit of **$1,000** of coverage and that I am responsible for any costs for services above that amount.

_____ I understand that only certain services are covered and that not all providers are considered In-Network and I will be responsible for any costs that are not covered or if I received services from a provider who is out-of-network.

_____ I understand that if I do not pay my share of the premium for services or if I dis-enroll from the program, I will need to cover costs for services beyond the covered period of enrollment AND wait one year to re-enroll.

_____ I agree to pay the annual premium determined by my income and family size.

My signature indicates that I agree to ALL of the above listed information and all terms and conditions for this program.

_____ _____

Signature Date

HFM/Cascade Dental Plan
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:
Hemophilia Foundation of Michigan
1921 W. Michigan Ave.
Ypsilanti, MI 48197
(734) 544-0015

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

_____

Name of Applicant's current Hemophilia Treatment Center and/or Hematologist

_____ _____

Address Phone Number

EXTENT OF AUTHORIZATION

☒ I authorize the release of the above-named applicant's information related to the HFM/Cascade Dental Plan application including eligibility for the program, status of the application, dental benefit coverage, dental care needs, and diagnosis and treatment of the above-named applicant's bleeding disorder.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by the person I authorize to receive this information to assist in determination of eligibility for the HFM/Cascade Dental Plan, billing or claims payment and management of dental program benefits and coordination of dental care.

I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to the Hemophilia Foundation of MI. I also understand that any uses or disclosures already made with my permission cannot be taken back. I understand that this consent will automatically expire if I am terminated from the Delta Dental Program.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for the HFM/Cascade Dental Plan unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor): _____
Date_____

Signature of Guardian/Personal Representative (if applicable):
_____

HFM/Cascade Dental Plan
Authorization to Disclose Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Applicant Name:_____ Date of Birth:_____

Parent/Guardian/Personal Representative (if applicable)

Name:_____ Relationship to Client:_____

AUTHORIZATION

I authorize:

Hemophilia Foundation of Michigan
1921 W. Michigan Ave.
Ypsilanti, MI 48197
(734) 544-0015

TO RELEASE the above-named applicant's protected health information TO AND OBTAIN Information FROM:

Cascade Hemophilia Consortium
517 W. William St.
Ann Arbor, MI 48103
(734) 996-3300

EXTENT OF AUTHORIZATION

☒ I authorize the release of the information contained on the HFM/Cascade Dental Plan application form including eligibility for the program, status of the application and dental benefit coverage.

☒ I understand that this release of information form does NOT include records relating to mental health care, communicable diseases (including HIV and AIDS) or alcohol/drug abuse treatment.

This information may be used by Cascade Hemophilia Consortium to verify applicant's dental benefits and to process payments of dental plan premiums. I understand that this information will NOT be used by Cascade Hemophilia Consortium in the marketing of any other services Cascade provides.

I understand that this consent will remain in effect until I give written notice to discontinue. I have the right to change my mind and revoke this authorization at any time. This must be in writing to the Hemophilia Foundation of MI. I also understand that any uses or disclosures already made with my permission cannot be taken back. I understand that this consent will automatically expire if I am terminated from the Delta Dental Program.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization but that my refusal to sign may effect my eligibility for dental benefits through the HFM/Cascade Dental Plan.

By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

Signature of Applicant or Parent (if minor):

_____Date_____

Signature of Guardian/Personal Representative (if applicable):

_____