IUD Access Program Application

Desert Star Institute for Family Planning, Inc understands that sometimes people face financial challenges, and we are here to help. We have partnered with Direct Relief, a charitable organization, to provide Liletta® intrauterine devices to qualified patients.

HOW DO I KNOW IF I AM ELIGIBLE?

You may be eligible for the IUD Access Program if you:

- Live in the United States.
- Have no insurance through your employer, AHCCCS/Medicaid/Medicare or any other public or private assistance for medications.
- Are a registered patient of Desert Star Family Planning clinic.

HOW DO I APPLY?

Complete and sign this application. Provide proof of address and financial documentation with your application.

YOUR NAME AND CONTACT INFORMATION

Name _____ Date of birth_____ /_____ /_____

Mailing address_____ City State_____ Zip code _____

Preferred contact □ Home_____ □ Cell_____ □ Work_____

Preferred contact time □ Morning □ Afternoon Your email address_____

YOUR HEALTHCARE INSURANCE INFORMATION

Do you have healthcare insurance? □ Yes □ No

YOUR HOUSEHOLD INCOME

How many people live in your household and are dependent on your household income (include yourself)?____
For example: you (1) + your spouse (1) + your children (2) + your parents (2) = 6

What is your total household income? $_____
This includes all income made by you and your relatives living in your household. Please include income earned by work wages, Social Security retirement benefit, Social Security disability benefit, unemployment, any pensions, and any other income including alimony and child support. Adding all of these numbers together gives your total household income.

You are required to submit proof of income, which includes any of the following (check all that apply):
□ Recent IRS Form 1040, Form 4506T, Form W2 □ Employer's letter □ Recent payroll check-stubs
□ Unemployment statement □ Social Security statement

Return in person, email, or fax completed application to: Desert Star Institute for Family Planning, 5501 N 19th Ave, Suite 420, Phoenix, AZ 85015. info@desertstarfp.org. 480.393.8121 (fax)

Patient Certification/Authorization:

I attest that all the information that I have provided to determine my eligibility for product donation programs is complete and correct to the best of my knowledge. I understand that I must provide proof of eligibility in order to participate in this program, and that I cannot request reimbursement for any medication received through this program from any government program or third-party insurer. I further agree to notify the clinic of any changes in my income, residency, insurance, or other factors used to determine my eligibility status were I to receive additional donated product in the future. I authorize the release of my Protected Health Information (PHI) to medication patient assistance programs or any third parties retained to administer these programs and who may audit my PHI for the purpose of verifying my eligibility.

Patient Signature: _____ Date: _____

Office Use Only

Proof of address document: _____ Staff initials: _____ Date: _____

Proof of income document: _____ Staff initials: _____ Date: _____

Program eligibility confirmed: □ Yes □ No

Notes: _____

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