2025 DENTAL PLAN APPLICATION

Valid: August 1, 2024 - December 31, 2025

Any applications received after August 1, 2024, will be processed using the 2025 Delta Dental Application. Applications approved after August 1, 2024, will receive coverage through December 31, 2025.

SECTION 1: INSTRUCTIONS

1. This form is for adults and parents/guardians of children wishing to **apply** for Delta Dental benefits through the HFM/Cascade Dental Plan.
2. Answer all questions and fill in all fields completely. An incomplete application will delay the application process.
3. Review the "checklist" (**Section 6**) at the end of this application to ensure you have provided all the required information.

If you have any questions about this application, please call or text Ashley Fritsch, HFM's Dental Program Assistant at 734-328-9717 or email her at afritsch@hfmich.org.

SECTION 2: INFORMATION ABOUT YOUR BLEEDING DISORDER

In order for your or your child's application to be processed, a current Verification of Bleeding Disorder (VBD) is required. Please include a VBD with this application, or send a VBD in letter format by mail, fax, or email. The VBD should be from the year 2024 and come from a doctor, hematologist, or Hemophilia Treatment Center (HTC) indicating you have a bleeding disorder.

Please DO NOT INCLUDE ANY MEDICAL RECORDS.

If you are unable to provide a VBD, you are ineligible to receive benefits.

1. Has the applicant been diagnosed with a bleeding disorder? ☐ Yes ☐ No
2. Does the applicant receive care at a Hemophilia Treatment Center (HTC)? ☐ Yes ☐ No

2a If **yes**, at which HTC do they receive treatment? _____

2b. If **no**, what is the name of applicant's Hematologist? _____

SECTION 3: APPLICANT INFORMATION

Social Security No.:_____ Date of Birth: ____/____/____

Full Name: _____ Preferred Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian (if applicable): _____ Phone: _____

Can we leave a message at this number? ☐ Yes ☐ No

Email Address: _____

SECTION 4: ENROLLMENT INFORMATION

1. Is the Applicant a resident of the state of Michigan? ☐ Yes ☐ No

2. Is the Applicant eligible for dental insurance through an employer? ☐ Yes ☐ No
*(If **No**, skip to #3)*

2a. If eligible for employer-sponsored dental insurance, why is the applicant not covered under that dental plan? _____

3. Does the applicant have coverage under CSHCS? ☐ Yes ☐ No
(Children's Special Health Care Services)

4. Does the Applicant have coverage under Medicaid? ☐ Yes ☐ No

5. Does the Applicant have coverage under Medicare? ☐ Yes ☐ No
*(If **No**, skip to #6)*

5a. Is it a Medicare Advantage Plan? ☐ Yes ☐ No
*(If **No**, skip to #6)*

5b. Does this Medicare Advantage Plan include dental coverage? ☐ Yes ☐ No

6. Is the Applicant covered under any other dental plan? ☐ Yes ☐ No

6a. If Yes, what plan is the Applicant covered under? _____

7. Does the Applicant have any special circumstances? ☐ Yes ☐ No
*(If **yes**, check all that apply below)*

If you have dental coverage and are applying for additional coverage, there must be a special circumstance that would make you eligible to receive dental coverage through this plan. Please note that exceptions for special circumstances are extended on a case-by-case basis/yearly renewal in coordination with your (or your child's) HTC Social Worker or Nurse.

☐ Access issue, **i.e.** unable to find provider in local area, transportation challenges, etc.
☐ Extensive dental work in the coming year
☐ Applicant has Medicaid coverage but dental work will be in excess of the their benefits
☐ Other, please explain: _____

SECTION 5: 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 is given to applicants based on their access to both resources and dental care. **I understand that I (or my child) may be placed on a waiting list if there are no spaces available when my (or my child's) application is received.**

2. I understand that until HFM approves my (or my child's) application no coverage will be effective.

3. I understand that I (or my child) am (is) 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 (or my child's) eligibility, including any dental insurance that I (or my child) may obtain in the future.

5. I understand that if I (or my child) move out of the state of Michigan, I must notify HFM so that I (or my child) can be dis-enrolled.

6. I understand that annual re-enrollment is necessary in order that my (or my child's) benefits remain active. I understand that if I do not complete the annual renewal application my (or my child's) enrollment will be terminated.

7. I understand that if I voluntarily dis-enroll myself (or my child), or if I (or my child) am (is) involuntarily dis-enrolled from the HFM/Cascade Dental Plan, I (or my child) may not reapply for at least one year after my (or my child's) coverage ends.

8. I understand that, by signing below, I certify that all information and documentation provided, as a part of this application are complete, accurate, and true to the best of my knowledge and belief.

_____ _____

Applicant or Parent/Guardian Signature **Date**

SECTION 6: CHECKLIST FOR SUBMITTING YOUR APPLICATION

☐ **Verification of Michigan Residency** (for child applicants, please provide for the parent/guardian completing this application)

- Submit a copy of a MI Driver's License or MI State ID Card (please note: dark or blurry copies will delay the application process)

OR

- Submit a copy of a recent utility bill, or similar bill, that includes your name along with a current Michigan address (within last 3 months)

☐ **Verification of Bleeding Disorder (VBD)**

- A **letter** from the applicant's treating doctor, hematologist, or Hemophilia Treatment Center verifying the applicant has a bleeding disorder. Please ask whomever is providing the applicant's treatment to email a letter via secure email to hfm@hfmich.org or fax the letter to (734) 544-0095. **PLEASE DO NOT SEND MEDICAL RECORDS**

☐ **Participant Acknowledgment of Responsibilities Form**
(this form is included in the application packet)

☐ **Delta Dental Authorization to Disclose Protected Health Information**
(this form is included in the application packet)

☐ **Please submit this application with all required documentation to:**

- **By Mail to:** Hemophilia Foundation of Michigan
  1921 W. Michigan Ave
  Ypsilanti, MI 48197
- **By Fax to:** (734) 544-0095
- **By Email to:** hfm@hfmich.org

Receiving a Determination

Applications may take a few weeks to process and initial determinations will be received by mail. Please make sure you provide a valid mailing address. If you have an immediate need for coverage, please contact Ashley Fritsch, HFM's Dental Program Assistant by phone at (734) 328-9717 or by email at afritsch@hfmich.org.

Applicant Acknowledgement of Responsibilities

Applicant Name: _____ **Date**: _____

The Hemophilia Foundation of Michigan and Cascade Hemophilia Consortium are pleased to be able to provide this program to you, and we thank you for your interest. We want to ensure that you fully understand the coverage provided as well as the limitations.

Please initial next to each statement below indicating that you understand and agree to your program responsibilities.

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

_____ I understand that I (or my child) 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 available on the internet, to verify my (or my child's) annual benefits.

_____ I understand that I am responsible to insure that my (or my child's) 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 (or my child) receive treatment.

_____ I understand that I (or my child) have (has) a maximum **Annual** benefit limit of **$1,000** 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. I will be responsible for any costs not covered, including if I (or my child) received services from an Out-Of-Network provider.

_____ I understand that if I dis-enroll myself (or my child) from the program, or my (or my child's) coverage is terminated; I will need to cover costs for services beyond the covered period of enrollment AND wait one year to re-enroll.

My signature indicates that I agree to **ALL** of the above listed information and all terms and conditions for this program and that all information provided in this application is accurate.

_____ _____

Applicant or Parent/Guardian Signature **Date**

Dental Plan Release of Information
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): _____

Relationship to Client: _____

AUTHORIZATION

I authorize the 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:

_____

Hemophilia Treatment Center and/or Hematologist

_____ _____

City **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 it to assist in determining my 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. Revocation must be in writing to the Hemophilia Foundation of Michigan. I also understand that any uses or disclosures already made with my permission may not be taken back. I understand that this consent will automatically expire if my benefits from the Delta Dental program terminate.

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 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 that the information may not be protected by federal privacy rules. I further understand that I may request a copy of this signed authorization.

_____ _____

Applicant or Parent/Guardian Signature **Date**