manyinfinities

Ruby L. Butler Patient Assistance Program

The Ruby L. Butler Patient Assistance Program helps provide patients diagnosed with one or more autoimmune diseases with unique items and services, directly related to the autoimmune diagnosis, which are not covered or fully covered by the patient's medical insurance(s). This program does not provide funding for drug prescriptions. Please contact Many Infinities, Inc. at www.manyinfinities.org to inquire about financial assistance with drug prescriptions.

Who Should Apply?

Any individual diagnosed with one or more autoimmune diseases, who meets the following criteria, is encouraged to apply for assistance with disease related needs, other than drug prescriptions.

- Applicant must be a US citizen
- Applicant must be diagnosed, by a physician, with one or more autoimmune diseases/disorders
- Applicant should be 18 years or older. Applicants under age 18 must be represented by a legal guardian.
- Applicant or guardian's annual household income is equal to or less than 200% of the current US Federal Poverty Guideline

How to Apply

When you have determined that you meet the Ruby L. Butler Patient Assistance Program criteria, follow these steps to complete the application process. All completed applications should be submitted, by mail, to

RLB Assistance Program
Many Infinities, Inc.
P.O. Box 1770
Alabaster, Alabama 35007

- Complete the patient information and need form.
- Only your licensed physician should complete the diagnosis and need verification form.
- Provide proof of identity (picture id, birth certificate, etc.)
- Provide proof of annual household income (most recent income tax statement(s)

*A completed application includes the patient information and need form, physician's diagnosis and need verification form, proof of identity, proof of annual household income, and all required signatures.

Other Important Information

- After submitting your completed assistance application, please allow 7-10 business days for contact regarding your application status.
- All applications must be submitted by mail. Emailed applications will not be considered.
- Upon approval of your application, each assistance recipient will be assigned a Case Manager who will work to ensure that program requirements and needs are being met.
- Should you have any questions regarding the Ruby L. Butler Patient Assistance Program, call us at (205) 258-0222 or email to info@manyinfinities.org.

Ruby L. Butler Patient Assistance Program

Application

Patient Information

Name: ____ Date: _______________________
Last First MI

Address: ____
Street City State Zip

Phone: (___) _____-_______ Alternate Phone: (___) _____-________ Email: _______________________________

SSN#: _____-_____-_______ ☐ Male ☐ Female Autoimmune Diagnosis: __________________________________

Are you currently receiving medical treatment for your diagnosis? ☐Yes ☐No

Guardian/Representative Information (If applicable)

Name: ____ Relationship to Patient: __________________
Last First MI

Address: ____
Street City State Zip

Phone: (___) _____-_______ Email: _______________________________

Financial Information (All information should reflect yearly amounts for the entire household)

Total Gross Household Income: $__________________________________ Household Size: _________________

☐ I have attached a copy of my most recent federal tax document
☐ I do not file federal taxes. I have attached proof of annual income.
☐ I have no income to report.

Number of people contributing to and dependent on household income.

Insurance Information

I have ☐ Medicaid ☐Medicare ☐Private Insurance.

Insurance Co. __________________________ Phone: _________________ Policy #: _________________

Group ID: ___________________ Subscriber's name: _____________________ Date of Birth: ___/___/______

Relationship to patient: ______________

Ruby L. Butler Patient Assistance Program

Patient's Full Name: ___________________________________

Product or Service Need

I am applying for assistance with ☐products ☐services that will help me in my day to day life, as it relates to my autoimmune disease/disorder diagnosis.

- Product Information
  - Product name, brand, and type: ____
  - Are you able to use generic brands? ______________
  - Are you currently purchasing this product? _______ If yes, from where? ______________________
    What is your estimated out of pocket cost per month? ____________________
  - Describe how requested product(s) will be used: ____
    ____
- Services Information
  - Service Description: _________________________ Service provider: ___________________________
    Phone: ________________ Address: ____
    Is this a Public provider ☐ or Privately contracted service ☐ ?
  - Are your currently receiving this service? ______ If yes, frequency? ____________ Duration? __________
    What is your estimated out of pocket cost per month? ______________________
  - Describe how this service will benefit the patient: ____
    ____
    ____

Please note that the details of your assistance are tailored to your circumstances. All details, including the type of assistance you receive (product donation, reimbursement, full or partial payment to provider, etc.) will be determined by the RLB Patient Assistance Committee. Upon program acceptance, details will be explained in your program award letter.

Patient Declaration

I __________________________ declare that

- The information provided in this application is true to the very best of my knowledge. I have neither withheld nor misrepresented any information provided.
- Upon acceptance into the Ruby L. Butler Patient Assistance Program, I will adhere to all program terms set forth by Many Infinities, Inc.
- I understand that Many Infinities, Inc. has the right to discontinue service or deem me ineligible for program services if all program terms are not met.
- Many Infinities, Inc., its representatives, and agents are not liable for any and all claims, injuries, damages, or loses arising out of or resulting from products and services for which I may receive assistance.
- I will notify Many Infinities, Inc. within thirty (30) days of any change in the status of my eligibility (income, household size, diagnosis, etc.) to receive services through the Ruby L. Butler Patient Assistance Program.
- My application does not guarantee my acceptance into the Ruby L. Butler Patient Assistance Program. I further understand that I will be notified of a reapply date and may apply for assistance on or after the designated date.
- Many Infinities, Inc. will hold financial information for one (1) year.
- Many Infinities, Inc. will only share the necessary information with program partners, as it directly relates to assisting my needs through the Ruby L. Butler Patient Assistance Program.

Patient's Name: ______________________________ Legal Guardian/Rep: ________________________________

Signature: __________________________________ Date: __________________

Ruby L. Butler Patient Assistance Program

Patient's Full Name: ____

Physician Consent and Information

I ____________________________ give my consent to my licensed physician/healthcare provider, ___________________________,
(patient's name) (healthcare provider)
to release information regarding my medical diagnosis of an autoimmune disease or disorder to Many Infinities, Inc. I understand that Many Infinities, Inc. will only use the provided medical information to determine the award details of the Ruby L. Butler Patient Assistance Program and will only share this information as it relates to services provided. I further understand that my physician nor any representatives are responsible for harm, damage, or loss occurring as a result of the product or service for which I am requesting assistance.

Patient's name: ____________________________________ Legal guardian/Rep: _____________________________________

Signature: ______________________________________ Date: _______________

Physician's Name: _____________________________________ Facility Name: ____

Address: ____ Phone: (___) ____-______ Fax: (___) ____-______
Street City State Zip

Office Contact Name: _______________________________________ Email: ____

Tax ID#: __________________

Check the applicable box and complete the diagnosis information.

☐ The patient named above is being treated for the following autoimmune diagnosis.

List diagnosis: ____

____

☐ The patient named above is not being treated, in this office, for an autoimmune diagnosis.

☐ It is my professional opinion that the requested assistance could be helpful to this patient, given his/her autoimmune diagnosis.

☐ It is my professional opinion that the requested assistance will not be helpful to this patient, given his/her autoimmune diagnosis.

Physician's Signature: _________________________________ Date: __________________