

## Patient Financial Aid Application Form

To apply for Patient Financial Aid from The Leukemia & Lymphoma Society, please complete this application, sign the form and ask your physician to verify your diagnosis and sign as indicated. Chapter staff will contact you with news of approval of your application.

Circle Mr Mrs Ms

Name (last, first, MI) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Country (if in military) \_\_\_\_\_

Home phone \_\_\_\_\_

Business phone \_\_\_\_\_

Email \_\_\_\_\_

Date of birth \_\_\_\_\_

U.S. resident? yes no Gender M F

Do you have a drug plan? yes no \_\_\_\_\_

Name of plan \_\_\_\_\_

Phone \_\_\_\_\_

Local pharmacy \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Do you receive assistance from other agencies? yes no \_\_\_\_\_

If yes, name of agency \_\_\_\_\_

Full address \_\_\_\_\_

Phone \_\_\_\_\_

Do you receive USAS veteran benefits? yes no \_\_\_\_\_

Who referred you to the Society? \_\_\_\_\_

### If the patient is a child...

Mother's/Guardian's name \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_

Mother's employer \_\_\_\_\_

Father's/Guardian's name \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_

Father's employer \_\_\_\_\_

Do you have health insurance? yes no \_\_\_\_\_

If yes, type Managed care (HMO) Traditional indemnity \_\_\_\_\_

Medicare Medicaid \_\_\_\_\_

Insurance company \_\_\_\_\_

Phone \_\_\_\_\_

Policyholder (insured person) \_\_\_\_\_

Deductible Individual \$ Family \$ \_\_\_\_\_

Patient/parent signature \_\_\_\_\_ Date \_\_\_\_\_

### For physician use only...

Date of diagnosis \_\_\_\_\_

Diagnosis \_\_\_\_\_

Physician name \_\_\_\_\_

Institution \_\_\_\_\_

Phone \_\_\_\_\_

Signature of attending physician \_\_\_\_\_ Date \_\_\_\_\_