



When completing the application for the Patient Financial Assistance program:

- Please be sure to complete the entire application and sign the medical release on the second page of the form.
- **We request a letter of diagnosis from your physician.** Frequently the nurses and social workers can obtain this for you.
- We request three years of income information. Please include a copy of your income tax return for the years 2018, 2017 and 2016 showing your adjusted gross income; accompanying schedules and information is not needed. Generally, the adjusted gross income appears on the first page of the tax return. If you have not filed taxes recently, please substitute a W-2 form, Social Security statement, disability statement, unemployment award or other verification of income.
- In the middle of the application there are two questions. If you answer “yes” to either question, please include a brief description of how your income may change and of any other medical conditions you may have.

Incomplete applications cannot be processed. Please be certain you have included your diagnosis verification and your income verification with your completed application. You can mail, email or fax your completed application to the Leukemia Research Foundation.

DO NOT send reimbursement requests along with your application.

If you have any questions, please feel free to contact us.

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Leukemia Research Foundation  
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# LEUKEMIA RESEARCH FOUNDATION

## APPLICATION FOR PATIENT FINANCIAL ASSISTANCE

**Instructions:** Complete this application (PLEASE PRINT) and return 1) completed application, 2) a letter of diagnosis from your physician, and 3) copies of your income tax returns for the last three years, to: Leukemia Research Foundation, 191 Waukegan Road, Suite. 105, Northfield, IL 60093 (Phone 847-424-0600). **ALL INFORMATION MUST BE COMPLETED FOR APPLICATION TO BE REVIEWED.**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Home Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Parent/Guardian (if patient is under 18): \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State ZIP: \_\_\_\_\_

Email Address: \_\_\_\_\_ County: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Patient's School (if applicable): \_\_\_\_\_ Number of people living in household: \_\_\_\_\_

Names, birthdates and relationships to patient: \_\_\_\_\_

**FAMILY GROSS INCOME FOR THE LAST THREE YEARS (MUST BE COMPLETED):**

<b>Applicant</b>	<b>2018</b>	_____	<b>2017</b>	_____	<b>2016</b>	_____
<b>Spouse</b>	<b>2018</b>	_____	<b>2017</b>	_____	<b>2016</b>	_____
<b>Other</b>	<b>2018</b>	_____	<b>2017</b>	_____	<b>2016</b>	_____
<b>TOTAL:</b>	<b>2018</b>	_____	<b>2017</b>	_____	<b>2016</b>	_____

Do you think your income will change significantly this year as a result of the diagnosis?  Yes  No **If YES, PLEASE ATTACH A DETAILED EXPLANATION.**

Does the patient have any other medical conditions?  Yes  No If YES, please list with related medications: \_\_\_\_\_

How did you hear about the Leukemia Research Foundation's Financial Assistance Program? \_\_\_\_\_

Physician's Name _____	Physician Phone _____
Hospital or Medical Center _____	Medical Center Address _____
Social Worker _____	Social Worker Phone _____
Primary Medical Insurance Coverage _____	Secondary Medical Insurance Coverage _____

**OPTIONAL:** Please note that answering these questions *does not* affect your eligibility for assistance from the Leukemia Research Foundation. These questions are being asked solely to gather statistical information.

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

- Race:  Caucasian  Hispanic  American Indian / Alaska Native  
 Asian  African-American  Native Hawaiian / Other Pacific Islander  
 Other (please specify): \_\_\_\_\_

Do you receive financial assistance from other organizations?  Yes  No If YES, which one(s)? \_\_\_\_\_





**LEUKEMIA RESEARCH FOUNDATION**  
RELEASE OF MEDICAL INFORMATION

**EXPLANATION**

The Leukemia Research Foundation requires specific documentation, including medical records and billing information, in order to process medical bills and reimbursements to patients who have been accepted into the financial assistance program.

\_\_\_\_\_  
*PATIENT'S NAME*

\_\_\_\_\_  
*DATE OF BIRTH (PATIENT)*

\_\_\_\_\_  
*PARENT/GUARDIAN NAME (if patient is under 18)*

\_\_\_\_\_  
*RELATIONSHIP TO PATIENT*

**AUTHORIZATION**

***(REQUIRED TO PROCESS APPLICATION)***

I hereby authorize any insurance company, employer, hospital, physician or pharmacy to release copies of medical records or other information concerning my diagnosis and treatment that may be necessary to process this application and any future financial assistance requests. I understand that this consent is a part of the application process for the financial assistance program. I consent to be bound by all regulations, procedures and decisions made by the Foundation in connection with this application. I certify that information supplied by me in support of this application is true and correct.

\_\_\_\_\_  
***SIGNATURE OF PATIENT***  
***OR PARENT/GUARDIAN (if patient is under 18)***

\_\_\_\_\_  
***TODAY'S DATE***