someday is today | LEUKEMIA & LYMPHOMA SOCIETY® fighting blood cancers

Applicant's Name: ____________________________________
DOB: _____/_____/_________

The Leukemia & Lymphoma Society's Travel Assistance Program

What is the Travel Assistance Program?
The Leukemia & Lymphoma Society's (LLS) Travel Assistance Program is available for qualified, blood cancer patients, with significant financial need, to help with transportation/travel expenses so that they can travel to health care providers for their blood cancer related treatments. A one-time grant of $250, per patient is available for qualified patients.

Program Criteria:
1. Be a US citizen or permanent resident.
2. Have a confirmed diagnosis of blood cancer.
3. Be at or below an annual income level of 500% of Federal Poverty Guidelines (see below).

Return the completed application to the LLS Patient Access Manager or the person from whom you received the application form.

Assistance is based on available funding and the program may be discontinued at any time, without notice.

2015 Health & Human Services Poverty Guidelines & Dollar Figures for 500% above the Federal Poverty Guidelines

Persons in Family or Household	48 Contiguous States Puerto Rico and D.C.	500%	Alaska	500%	Hawaii	500%
1	$11,770	$58,850	$14,720	$73,600	$13,550	$67,750
2	$15,930	$79,650	$19,920	$99,600	$18,330	$91,650
3	$20,090	$100,450	$25,120	$125,600	$23,110	$115,550
4	$24,250	$121,250	$30,320	$151,600	$27,890	$139,450
5	$28,410	$142,050	$35,520	$177,600	$32,670	$163,350
6	$32,570	$162,850	$40,720	$203,600	$37,450	$187,250
7	$36,730	$183,650	$45,920	$229,600	$42,230	$211,150
8	$40,890	$204,450	$51,120	$255,600	$47,010	$235,050
For each additional person add	$4,160	$20,800	$5,200	$26,000	$4,780	$23,900

The above Federal Poverty Guidelines adapted scale is to be used as a reference tool only, it does not guarantee acceptance into the program.

Your income can also be impacted by the Cost of Living Index (COLI) in your area. To be eligible for the Travel Assistance Program, your household income must be at or below 500% of the Federal Poverty Level as adjusted by the Cost of Living Index (COLI).

SOURCE: *Federal Register,* January 22, 2015
http://aspe.hhs.gov/poverty/15poverty.cfm#guidelines

Adapted by The Leukemia & Lymphoma Society's Travel Assistance Program

someday is today | LEUKEMIA & LYMPHOMA SOCIETY® fighting blood cancers

Applicant's Name: ___________________________________
DOB: _____/_____/_________

The Leukemia & Lymphoma Society's Travel Assistance Program
- Application Form -

The application must be completed in its entirety, and must be signed by both the physician and the patient in the areas specified on the form below.

Patient Information

Patient First and Last Name: ____

If patient is less than 18 years of age, please also provide parent/guardian first and last name:

Address: ____ Apt. # _______

City/State/ZIP: ____

Country (if military): ______________________________ Email: ____

Home Phone: (   ) ___________________________ Work or Cell Phone: (   ) _____________________________

How did you hear about the Travel Assistance Program?

☐ Doctor ☐ Nurse ☐ Social Worker ☐ Friend/Family Member

☐ Other (please specify): ____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_________

Are you of Hispanic or Latino origin or descent? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Which of the following best describes your race? ☐ White or Caucasian ☐ Black or African-American ☐ Asian

☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Other___________________

Medical Information

To be completed by the patient's prescribing healthcare provider or designee. Please note, stamps or initials will not be accepted.

Patient Diagnosis/Subtype: ____

Date of Diagnosis: ___________________ Is patient in active treatment and/or ongoing follow-up? ☐ Yes ☐ No

Healthcare Provider Name: ______________________________ Hospital/Clinic: _____________________________

Desginee Name/Title: ____

Address: ______________________________________ City/State/ZIP: _____________________________________

Phone: (   ) __________________________ Healthcare Provider License #: _____________________________

Healthcare Provider Signature: ____ Date: _____/_____/_________

someday is today | LEUKEMIA & LYMPHOMA SOCIETY® fighting blood cancers

Applicant's Name: ___________________________________

DOB: _____/_____/_________

The Leukemia & Lymphoma Society's Travel Assistance Program
- Application Cont'd -

Health Insurance Information

Do you currently have health insurance? ☐ Yes ☐ No. If yes, please check which one :

Medicare Part B: ☐ Medicare Part D: ☐ Medicaid: ☐ Health Exchange Plan: ☐ Commercial: ☐
Other ☐ (if other, please specify)

Are you currently receiving assistance from the LLS Co-Pay Assistance Program? ☐ Yes ☐ No

Household Financial Information

Number of people in the household: ____________ Is the patient/guardian currently employed? ☐ Yes ☐ No

Current annual household income: _________________________

Patient Signature & Attestation

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate, and if asked, I agree that I can, and will, provide documentation showing that the household's annual income is equal to or less than 500% of the Federal Poverty Level, examples of which have been provided to me with this application form.

I further attest that if approved for a travel grant, the funds will be used for treatment-related travel.

Patient/Guardian Signature ____ Date: _____/_____/_________

Patient/Guardian Print Name: ____

This program is provided by The Leukemia & Lymphoma Society and is supported in part by a grant from an independent donor for use within the Southern Florida and Puerto Rico chapter. Thanks to Miami Cancer Institute at Baptist Health South Florida for providing this funding which is available only to patients being treated at a Baptist Health South Florida Treatment Center.

Miami Cancer Institute

BAPTIST HEALTH SOUTH FLORIDA