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

Applicant's Name: _____

DOB: _____/_____/_____

The Leukemia & Lymphoma Society's
Susan Lang Pay-It-Forward Patient Travel Assistance Program

What is the Travel Assistance Program?

The Leukemia & Lymphoma Society's (LLS) Susan Lang Pay-It-Forward Travel Assistance Program is available for qualified, blood cancer patients, with significant financial need, to help with transportation/travel and lodging expenses so that they can travel to health care providers for their blood cancer related treatments. A one-time grant of $500, per patient is available for qualified patients.

Program Criteria:

1. Applicants (patients) must be US citizens or permanent residents and residents of Snohomish County which is verified by applicant's physical address; and
2. Applicants must have a confirmed diagnosis of blood cancer; and
3. Applicants may be insured or uninsured; and
4. Applicants must meet financial eligibility criteria defined as an annual income at or below 500% of the Federal Poverty Level (FPL) (see below)
5. Applicants must not have received an award from the Susan Lang Pay-It-Forward Patient Travel Assistance Program in the same fiscal year (July1 –June 30).

Return the completed application to LLS either by fax or email

Fax number: 206-292-9791 **Email**: Christine.Means-Wallace@lls.org **For questions:** 206-957-4585

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

2017 Household Income Requirements for The Leukemia & Lymphoma Society's Assistance Programs.

To be eligible for The Leukemia & Lymphoma Society's financial assistance programs, your household income level must be at or below 500% of the Federal Poverty Guidelines. Please use this chart to estimate your eligibility.

Persons in Family or Household	If you live in 48 Contiguous States, Puerto Rico and D.C.	If you live in Alaska	If you live in Hawaii
	Your household income must be at or below	Your household income must be at or below	Your household income must be at or below
1	$59,400	$74,200	$68,350
2	$80,100	$100,100	$92,150
3	$100,800	$126,000	$115,950
4	$121,500	$151,900	$139,750
5	$142,200	$177,800	$163,550
6	$162,900	$203,700	$187,350
7	$183,650	$229,600	$211,150
8	$204,450	$255,600	$235,050
For each additional person add	$20,800	$26,000	$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 25, 2016
https://aspe.hhs.gov/poverty-guidelines
Adapted by The Leukemia & Lymphoma Society's Patient Travel Assistance Program

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

Applicant's Name: _____

DOB: _____/_____/_____

The Leukemia & Lymphoma Society's
Susan Lang Pay-It-Forward Patient 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): _____

Are you currently receiving travel assistance via the Susan Lang Pay-It-Forward Credit Card: ☐ Yes ☐ No

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 the 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 #: _____

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

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

Healthcare Provider Signature: _____ Date: _____/_____/_____

The Leukemia & Lymphoma Society's
Susan Lang Pay-it-Forward Patient 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: _____
Employer Company Name: _____
If patient is a student, school name: _____

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 and lodging.

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 the Verdant Health Commission for use within the Washington/Alaska Chapter.

verdant
HEALTH COMMISSION
SERVING SOUTH SNOHOMISH COUNTY