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):***

Applicant	**2017**	_____	**2016**	_____	**2015**	_____
Spouse	**2017**	_____	**2016**	_____	**2015**	_____
Other	**2017**	_____	**2016**	_____	**2015**	_____
TOTAL:	**2017**	_____	**2016**	_____	**2015**	_____

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)? _____

Rev 2/18

SIGNATURE REQUIRED: SEE OTHER SIDE

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***