



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)? _____





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