Patient Assistance Programs

LEA'S FOUNDATION FOR LEUKEMIA RESEARCH INC

Where hope and help come together.

Medical Assistance:

Restricted to CT patients and to non-residents being treated in Connecticut Hospitals.

This program is covered under our broad program of Patient Services and is designed to assist patients and their families, to help defray the non-insured cost of expensive treatments for blood related cancers.

Diseases covered are leukemia, lymphoma, Hodgkin's lymphoma, multiple myeloma, myelodysplastic syndrome (MDS) and other malignant diseases of bone marrow.

Applications for assistance are sent to those requesting financial aid whose diagnosis falls within the Foundation's guidelines and are confirmed by a qualified physician. Patients must be currently under a physician's care to request financial aid.

Financial aid covers the cost of medical services, medications *specific to the patient's disease* beyond insurance coverage, travel expenses for public transportation, personal auto at $.25 per mile, parking, tolls, office visits and limited housing for special circumstances after review.

Grants under this program are awarded up to $1,500. Grants inactive after 6 months from approval date will be cancelled. After initial award has been fully utilized, patients may apply for one additional award following a 90 day waiting period from the date of the first award.

Non-Medical Assistance:

Restricted to CT patients and to non-residents being treated in Connecticut Hospitals.

This program is covered under our broad program of Patient Services and is designed to assist patients and their families to help defray the non-insured, *non-medical expenses* encountered while obtaining treatment for Leukemia and its related cancers.

Diseases covered are leukemia, lymphoma, Hodgkin's lymphoma, multiple myeloma, myelodysplastic syndrome (MDS) and other malignant diseases of bone marrow.

Applications for assistance are sent to those requesting financial aid whose diagnosis falls within the Foundation's guidelines and are confirmed by a qualified physician. Patients must be currently under a physician's care to request financial aid.

Assistance under this program include the following expenses only:
Electric Bill
Gas/Propane/Oil used for home heating
Water Bill
Rent/Mortgage assistance only if the patient has not received additional financial aid from another social program, such as, but not limited to Section 8 housing.

Grants under this program are limited to households with taxable income of $60,000 or less and are for expenses up to $1,000.00. Patients may apply for one grant per year with a maximum of 3 grants per patient. Grants inactive after 6 months from approval date will be cancelled.

Patient Assistance Programs

Program guidelines, please read entirely before filling out application.

All financial aid applications require approval by the Board of Directors or the Administrators appointed by the Patient Services Committee. Financial aid award limits will be reviewed and set each fiscal year by a vote of the Board of Directors. *Receipt of application does not guarantee awarding of funds.*

Grants under the Medical program are limited to 2 awards per fiscal year. Non-Medical grants are limited to 1 award per year, with a maximum of 3 grants per patient. Medical Financial Aid and Non-Medical awards may not be combined, however, patients may apply for either grant after their first award, i.e. applying for a Non-Medical Assistance grant after receiving a Medical Assistance grant. Bills will be paid only for the award granted. Utility bills will not be paid under medical assistance grants and medical expenses will not be paid under Non-Medical Assistance grants. If such bills are submitted, they will be rejected and mailed back to the applicant. Only Medical Assistance grants may request a second grant in the same fiscal year. Awards for Medical assistance will only be considered after the mandatory 90 day waiting period.

Total awards granted to any single applicant for medical assistance during any one fiscal year is $3,000. Special requests for additional aid shall be determined by a vote of the Board of Directors.

Financial aid assistance for either program is limited to expenses not covered by all insurances and fund-raising activities for the patient. Any exceptions to the program limits must be approved by a vote of the Board of Directors.

Applications are reviewed in the order received. Applications for Medical Assistance will receive priority over applications for Non-Medical Assistance. First time applicants will receive priority over 2nd request applications. Applications must be completely filled out. Incomplete applications will be returned to the patient. Applicants will be notified by mail if they have been granted financial aid with the amount they have been granted. Granted funds must be used within 6 months from approval date. Any funds unused at the end of the 6 month period will go back into the general financial aid fund.

Financial aid applicants must submit copies of current tax return form 1040 or 1040EZ and copies of medical bills with their application, along with a brief synopsis detailing why financial aid is needed. Financial assistance is available to households with taxable household income of $60,000 or less.

It is the Foundation's preference to make payments directly to the providers and looks at applicant reimbursement only as a second means of payment. For mortgage awards, please provide a copy of your current mortgage coupon/payment stub with loan # and mailing address. For rent awards, please provide a copy of your current lease, landlord's name, and billing address. For all other awards, please provide copies of the actual bills you wish to have paid. To ensure that bills are paid on a timely manner, please be sure to allow at least to two weeks before due date for postal delivery for bills to be processed and mailed.

Patient Services Application

Restricted to CT patients and non-residents who are being treated in CT area hospitals.

Date: ______________________________

Patient Information:

First Name: ______________________________________ Last Name: _________________________________

Date of Birth: _______________________________________Age: ________________Sex: _______________

Address: ____

City: ____State:_______________Zip: __________________

Phone:____ Email: _________________________________

Responsible Family Member: ____

Relationship to patient:____

Email: ____ Phone: _____________________________

Physician & Social Worker Information:

Date of Diagnosis: ___________________________ Diagnosis:________________ Type:_________________

Hospital: ____

Address: ____

City:_______________________________________ State: ___________________Zipcode: _______________

Social Worker/Nurse Coordinator: ____

Email: ____Phone: _________________________________

Physician: ____

Physician/APRN Signature: ____

Financial Information:

Aid received or pending from other organizations (Organization and amount): ___________________________

____

Current medical, living, family and financial situation (attach separate page if necessary) :

____

Financial Aid Request: **Choose either Medical Assistance or Non- Medical Assistance**

Medical Assistance	**Non-Medical Assistance**
_____ Medical Expenses _____ Transportation	_____Rent/Housing _____ Utilities (Electric/Water/Home Heating only)

Amount of Financial Aid Requested- be specific:

____

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Patient Services Application

Estimated Monthly Household Income

Income:_______________ Disability:____________

Unemployment: __________ Pension:___________

Social Security: ___________ Other: ____________

Estimated Monthly Household Expenses

Rent/Mortgage:_______________ Utilities: ________________

Medical Insurance: ____________Transportation: ___________

Outstanding Expenses:________ Medical Expenses:_________

Patient's Insurance: ____

Deductible:____

Diseases covered are leukemia, lymphoma, Hodgkin's lymphoma, multiple myeloma, myelodysplastic syndrome (MDS) and other malignant diseases of the bone marrow.

Applications for assistance by those requesting financial aid must have a diagnosis fall within the Foundation's guidelines and are confirmed by a qualified physician. All financial aid applications require approval by the Board of Directors or the Patient Services Committee established by the Board.

Financial assistance covers:

The cost of medical services, *medications specific to the patient's disease* beyond insurance coverage
Travel expense for public transportation
Personal auto at $.25 per mile
Parking and tolls
Office visits (non-insured)
Rent/Mortgage- provided only if not covered under another social program, such as, but not limited to Section 8 Housing
Utilities (limited to Electric Bill, Home Heating Bills, and Water Bills)

I, ___________________________________, give Lea's Foundation for Leukemia Research, Inc. permission to discuss
(patient/guardian's name)

my medical condition and financial status among members of the Patient Services Committee to the extent of processing my application for financial assistance. I understand that none of my personally identifiable information will be disclosed to any other party beyond the Patient Services Committee.

I acknowledge that a Patient Services Committee member may contact me regarding the services that Lea's Foundation for Leukemia Research, Inc. provides through the Patient Services Program.

Upon approval you will be sent a letter directing you where to send your bills and what amount you were awarded.

Financial aid award limits will be reviewed and set each fiscal year by a vote of the board of directors.

After a Medical award has been fully utilized, patient families may apply for one additional award. Non-Medical awards are limited to one award per year. Financial aid assistance is limited to expenses not covered by all insurances and fund raising activities for the patient. Any exceptions to the program limits must be approved by a vote of the Board of Directors.

Any funds not fully utilized within 6 months from date of award approval will be put back into the Patient Services general fund.

It is the Foundation's preference to pay provider's expenses directly to ensure the money goes where intended. Applicants who have been approved will be asked to submit any expenses to the Patient Services Committee for payment. Mileage, parking, toll, and medication reimbursement will be paid directly to the patient.

Administrative services provided for free by Becon, Inc. on behalf of Lea's Foundation for Leukemia Research, Inc., and as such Becon employees may see personal and medical information. This information will be limited to processing applications and paying providers. Patient names will not be disseminated by review committee or shared with any organization outside of Lea's Foundation.

I certify I have read and understand the Patient Services guidelines and agree to abide to these guidelines:

Signature:____Date:_____________________5

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