

RETURN TO YOUR LOCAL CHAPTER



You can find the name and address of your Chapter by calling (800) 955-4572 or visiting www.LLS.org, entering your zip code and clicking on Chapter Finder.

Request for Patient Financial Aid

For more information, call your local Chapter or (800) 955-4572 or visit www.LLS.org.

If you or a loved one have leukemia, lymphoma, myeloma, myelodysplastic syndromes or another blood cancer and need financial aid (up to \$500 per year), please complete and return this form to your local Chapter. Please remember to ask your healthcare provider to complete and sign the box at the bottom of the page. This information is confidential.

Patient First and Last Name _____

If patient is less than 18 years old please provide

Parent/Guardian First and Last Name _____

Address _____

City/State/Zip _____

County _____

Country (if military) _____

Home Phone () _____

Work or Cell Phone () _____

Email _____

Patient Information

Gender Male Female

Date of Birth _____

Date of Diagnosis _____

Ethnicity African American Asian Caucasian Hispanic Native American Other

Do you have health insurance? Yes No

Do you have a prescription drug plan? Yes No

Do you have Medicare? Yes No

Do you have Medicaid (Title 19)? Yes No

Would you like to list another person for us to contact on your behalf?

First and Last Name _____

Phone (if different than above) _____

Email _____

Relationship to patient (check all that apply)

Caregiver Spouse/Domestic Partner Parent Child Sibling Friend/Concerned Individual Other _____

Patient/Parent Signature _____

Date _____

Thank you. Your chapter staff will contact you about your application within 7 business days.

- To be completed by patient's doctor, nurse or social worker -

Patient Diagnosis _____

Is Patient In Active Treatment? Yes No

Provider Name _____

Hospital/Clinic _____

Address _____

City/State/Zip _____

Phone _____

Provider Signature _____

Date _____

Note: Physician Nurse Social Worker