Return To Your Chapter

Kentucky & Southern Indiana Chapter
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LEUKEMIA & LYMPHOMA SOCIETY®
fighting blood cancers

JULY 2011 TO JUNE 2012

Patient Financial Aid Application*

The Leukemia & Lymphoma Society (LLS) **Patient Financial Aid** program is for patients **with significant financial need**. *Please contact LLS to find out if you are eligible for the Co-Pay Assistance Program before applying for patient financial aid. For eligible patients, LLS **Co-Pay Assistance Program** may offer a larger amount of financial support for select diseases towards the cost of insurance co-payments and/or insurance premium costs for prescription drugs. For more information, or to apply for the Co-Pay Assistance Program, call (877) 557-2672 or visit www.LLS.org/copay. **Co-Pay assistance is based on fund availability.**

The **Patient Financial Aid** program provides $100 per year to help patients offset expenses. Receipts for expenses are not required. To apply, you or a loved one must be a US resident and be in active treatment or ongoing medical follow up for leukemia, lymphoma, myeloma, myelodysplastic syndromes or another blood cancer. Please have your prescribing healthcare provider complete and sign the box on the bottom of this form. This information is confidential. Please complete and return this form to your chapter. You can find your chapter by calling **(800) 955-4572** or visiting **www.LLS.org** and entering your ZIP code into "Find Your Chapter." If you choose to fax your form, you still need to mail your chapter a hard copy with the original signatures.

The Reimbursement Period

- The Patient Financial Aid Program begins each July 1 and ends each June 30.
- Each year (after June 30), you will need to submit a new application form to your chapter to reapply for the program.
- **All reimbursement is based on Patient Financial Aid Fund availability during the program period.**

Patient Information

Patient First and Last Name _____

If patient is less than 18 years old please provide Parent/Guardian First and Last Name _____

Address _____ Apt. # _____ City/State/ZIP _____

County _____ Country *(if military)* _____

Home Phone ( ) _____ Work or Cell Phone ( ) _____ Email _____

How did you hear about LLS? ☐ LLS website ☐ Doctor ☐ Nurse ☐ Social Worker ☐ Friend/Family Member ☐ Other _____

Gender: ☐ Male ☐ Female Date of Birth _____

Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ American Indian ☐ 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

Are you currently receiving assistance from the LLS Co-Pay program? ☐ 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 _____

To be completed by the patient's prescribing healthcare provider *Please note: signatures must be original; stamps, photocopies, or initials will not be accepted.*

Patient Diagnosis/subtype _____

Date of Diagnosis _____ Is Patient in Active Treatment and/or Ongoing Follow-Up? ☐ Yes ☐ No

Healthcare Provider Name _____ Hospital/Clinic _____

Address _____ City/State/ZIP _____

Phone _____ Healthcare Provider License # _____

Healthcare Provider Signature _____ Date _____