



Request for Patient Financial Aid Application Form

The Leukemia & Lymphoma Society (LLS) offers up to \$150 per year to help patients offset expenses. Receipts for expenses are not required. To apply, you or a loved one must be a U.S. resident and be in active treatment or ongoing medical follow up for leukemia, lymphoma, myeloma, myelodysplastic syndromes or another blood cancer. Please remember to have your physician complete and sign the box on the bottom of this page. This information is confidential. Please complete and return this form to your local Chapter. You can find your local Chapter by calling (800) 955-4572 or visiting www.LLS.org and clicking on 'Chapter Finder'. If you choose to fax your form, you will 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.
- You will need to reapply every year (after June 30).
- All reimbursement is based on Patient Financial Aid Fund availability during the program period.

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

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 _____

Thank you.

- To be completed by patient's doctor -

** Please note: signatures must be original; stamps, photocopies, or initials will not be accepted.**

Patient Diagnosis _____

Is Patient in Active Treatment and/or Ongoing Follow-Up? Yes No

Provider Name _____ Hospital/Clinic _____

Address _____ City/State/Zip _____

Phone _____

Physician Signature _____ Date _____

Physician License # _____