

The Leukemia & Lymphoma Society's Susan Lang Pay-It-Forward Patient Travel Assistance

What is the Travel Assistance Program?

The Leukemia & Lymphoma Society's (LLS) Travel Assistance Program is available for qualified, blood cancer patients, with significant financial need, to help with transportation/travel expenses so that they can travel to health care providers for their blood cancer related treatments. A one-time grant of \$500, per patient is available for qualified patients.

Program Criteria:

1. Be a US citizen or permanent resident.
2. Be a resident of one of the following counties:
 Imperial, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, & Ventura
3. Have a confirmed diagnosis of blood cancer.
4. Be at or below an annual income level of 500% of Federal Poverty Guidelines (see below).

Return the completed application to the LLS Patient Access Manager

*Assistance is based on available funding and the program may be discontinued at any time, without notice.

2015 Health & Human Services Poverty Guidelines & Dollar Figures for 500% above the Federal Poverty Guidelines

Persons in Family or Household	48 Contiguous States Puerto Rico and D.C.	500%	Alaska	500%	Hawaii	500%
1	\$11,770	\$58,850	\$14,720	\$73,600	\$13,550	\$67,750
2	\$15,930	\$79,650	\$19,920	\$99,600	\$18,330	\$91,650
3	\$20,090	\$100,450	\$25,120	\$125,600	\$23,110	\$115,550
4	\$24,250	\$121,250	\$30,320	\$151,600	\$27,890	\$139,450
5	\$28,410	\$142,050	\$35,520	\$177,600	\$32,670	\$163,350
6	\$32,570	\$162,850	\$40,720	\$203,600	\$37,450	\$187,250
7	\$36,730	\$183,650	\$45,920	\$229,600	\$42,230	\$211,150
8	\$40,890	\$204,450	\$51,120	\$255,600	\$47,010	\$235,050
For each additional person add	\$4,160	\$20,800	\$5,200	\$26,000	\$4,780	\$23,900

The above Federal Poverty Guidelines adapted scale is to be used as a reference tool only, it does not guarantee acceptance into the program.

Your income can also be impacted by the Cost of Living Index (COLI) in your area. To be eligible for the Travel Assistance Program, your household income must be at or below 500% of the Federal Poverty Level as adjusted by the Cost of Living Index (COLI).

SOURCE: Federal Register, January 22, 2015
<http://aspe.hhs.gov/poverty/15poverty.cfm#guidelines>

Adapted by The Leukemia & Lymphoma Society's Travel Assistance Program

The Leukemia & Lymphoma Society's Susan Lang Pay-It-Forward Patient Travel Assistance - Application Form -

The application must be completed in its entirety and must be signed by the patient in the areas specified on the form below.

Patient Information

Patient First and Last Name: _____

Address: _____ Apt. # _____

City/State/ZIP: _____

Country (if military): _____ Email: _____

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

Gender: Male Female Primary Language: _____ Date of Birth: ___/___/___

How did you hear about the Travel Assistance Program?

Doctor Nurse Social Worker Friend/Family Member

Other (please specify): _____

Are you of Hispanic or Latino origin or descent? Hispanic or Latino Not Hispanic or Latino

Which of the following best describes your race? White or Caucasian Black or African-American Asian

Native Hawaiian or other Pacific Islander American Indian or Alaska Native Other _____

(Optional)

Would you like to list another person to contact on your behalf? Yes No

Preferred Contact: _____

If patient is less than 18 years of age, please provide parent/guardian first and last name

Is the Preferred Contact authorized to discuss account? Yes No Relationship to Patient: _____

Phone (if different from above): () _____ Email: _____

Medical Information

Patient Diagnosis/Subtype: _____

Date of Diagnosis: ___/___/___ Is patient in active treatment and/or ongoing follow-up? Yes No

Healthcare Provider Name: _____ Hospital/Clinic: _____

Healthcare Provider Title: _____ Phone: () _____

Address: _____ City/State/ZIP: _____

The Leukemia & Lymphoma Society's Susan Lang Pay-It-Forward Patient Travel Assistance - Application Cont'd -

Health Insurance Information

Do you currently have health insurance? [] Yes [] No If yes, please check which one: [] Medicare Part B [] Medicare Part D [] Medicaid [] Health Exchange Plan [] Commercial [] Other (if other, please specify) _____

Are you currently receiving assistance from the LLS Co-Pay Assistance Program? [] Yes [] No Are you currently receiving financial assistance from any other organizations? [] Yes [] No

Household Financial Information

Number of people in the household: _____ Is the patient/guardian currently employed? [] Yes [] No Current annual household income: _____ Marital Status: _____ Source of household income? (Check all that apply)* [] Alimony [] Child Support [] Employment [] Retirement Pension [] Social Security [] Self Employment [] Tax Return [] Other Income: _____

Patient Signature & Attestation

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate, and if asked, I agree that I can, and will, provide documentation showing that the household's annual income is equal to or less than 500% of the Federal Poverty Level, examples of which have been provided to me with this application form.

I further attest that if approved for a travel grant, the funds will be used for treatment-related travel.

Patient/Guardian Signature _____ Date: ____/____/____

Patient/Guardian Print Name: _____

The Susan Lang Pay-It-Forward Patient Travel Assistance program is provided and managed by The Leukemia & Lymphoma Society and is supported through funding from Stater Bros. Charities for use within the Southern California chapters. All inquiries regarding the Susan Lang Pay-It-Forward Patient Travel Assistance program should be directed to The Leukemia & Lymphoma Society.

For the following counties please send to the LLS California Southland Chapter: Imperial • Los Angeles • Orange • Riverside • San Bernardino • San Diego • Santa Barbara • Ventura Fax: (714) 481-5677 Email: leila.evangelista@lls.org Phone: (714) 481-5640 Mail: 765 The City Drive South, Suite 450 Orange, CA 92868

