



## Leukemia Texas Patient Aid Application Eligibility and Process

*Leukemia Texas is an independent nonprofit corporation dedicated to fighting the life-threatening blood cancer of leukemia through the funding of leukemia research and patient aid in Texas. Through its Patient Aid program, Leukemia Texas provides financial assistance to leukemia patients needing help with their necessary treatment expenses. This program currently serves hundreds of children and adults each year.*

Thank you for applying for patient aid through Leukemia Texas. Leukemia Texas is an independent nonprofit corporation dedicated to fighting the life-threatening blood cancer of leukemia through the funding of leukemia research and patient aid in Texas. Through our Patient Aid program, Leukemia Texas provides financial assistance to leukemia patients needing help with their necessary treatment expenses. This program currently serves hundreds of children and adults each year.

### Eligibility:

- Patient must be diagnosed and currently undergoing treatment for any form of leukemia.
- Patient must be a legal citizen or legal resident of the United States of America.
- Patient must be a legal resident of and currently live in the state of Texas.
- Patient's treatment and diagnoses must be validated by two persons providing care or assistance to the patient through their current physician's office or hospital.
  - Those that can provide signature (need two):
    - Physician (MD or DO)
    - Physician Assistant
    - Nurse Practitioner
    - Social Worker
    - Financial Advisor
    - Practice Manager
- Patient must be alive at the time that the aid is issued. Financial assistance related to postmortem expenses or expenditures incurred after death will not be considered.
- Applicants may receive aid once within a twelve-month period. Window is based on when aid is received not on when application is submitted.

### Process:

1. If patient meets the eligibility criteria outlined above, they may apply for patient aid.
2. Application can be downloaded from our website or filled out online at [www.leukemiatexas.org](http://www.leukemiatexas.org)
3. Application must be legible and complete. For best results, fill out the application online prior to printing out, or submit online.
  - a. Application must contain two signatures from physician or hospital staff along with all diagnosis information requested.
  - b. Application must be signed by patient or legal guardian in order to be considered complete.
4. Once application is complete, submit via email or mail prior to due date listed on the application:
  - a. **Email:** [PatientAid@leukemiatexas.org](mailto:PatientAid@leukemiatexas.org)
  - b. **Mail To:**  
Leukemia Texas,  
c/o Patient Aid,  
4925 N. O'Connor Road,  
Suite 125  
Irving, TX 75062
5. Once received, application will be held until processing which occurs within six (6) weeks after deadline.
6. Once all applications are processed, we will notify all applicants of the status of their application in writing via US mail.
  - a. If you have not heard from Leukemia Texas eight weeks after deadline, please reach out to Leukemia Texas to check on the status of your application



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- b. Leukemia Texas relies on the accuracy of the information provided on each application. If you have a change of address after you submit your application, please reach out to Leukemia Texas to provide us with the current information.
7. Leukemia Texas reserves the right to request additional documentation to validate application information.
8. Leukemia Texas reserves the right to request a new annual application for all enrollees to ensure system accuracy and applicant eligibility, as we update our application each quarter.
9. If you have any questions, please feel free to contact Leukemia Texas at (214) 265-7393 or [PatientAid@leukemiatexas.org](mailto:PatientAid@leukemiatexas.org)

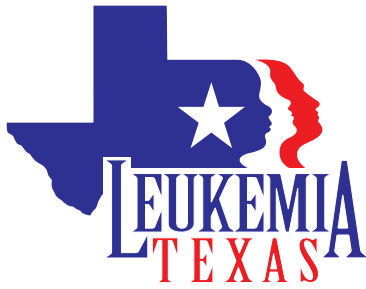
### **Priorities of Leukemia Texas when approving Patient Aid:**

*(Priorities are not a determination of approval or denial, but a tool for our committee to evaluate our applicants based on our mission and patient needs)*

- Leukemia Texas was founded to assist patients across Texas, specifically with a leukemia diagnosis of any type. Due to the wide scope of the population that is affected by leukemia, we as an organization, do our best to serve those in greatest need, while understanding that all leukemia patients are in need of some sort or another.
- Leukemia Texas requests that all applicants provide as much information as possible on their application to give our Program Committee the best idea of how their leukemia diagnosis has affected them financially. In the narrative, please provide a description of the current financial state the patient is in due to the diagnosis:
  - Provide information about what financial strains are put on the patient due to the current treatment plan they are or will be going through.
  - Provide information on any other obstacles that are now adding to the financial strain due to the leukemia diagnosis.
- Leukemia Texas and the Program Committee will look at all information provided in the patient's application to determine their priority when compared to all other applications submitted:
  - Leukemia Texas priority for patients:
    - Priority will be given to those patients that have expressed a financial need based on the treatment they will undergo requiring 100+ visits to the hospital for treatment
    - Priority will also be given to those that may require travel of longer distances to receive their therapy, incurring higher expenses due to the length of travel, cost of parking or even multiple overnight stays during treatment
    - Priority will be given to those patients in a situation of little or no insurance.

This priority is not stating that simply because one has insurance they will not receive priority over someone else. Insurance can be present, but still have very costly attributes, i.e. high deductibles and prescription copays. Through proper description of their financial situation in the narrative of the application, patients are able to best present their need, even while having insurance.

We also recognize that certain treatments are not covered by insurance, i.e. experimental medications, clinical trials, etc.
- Patients that are US citizens or legal US residents, residents of Texas and currently undergoing treatment for any form of leukemia are still able to apply, but realize that we look at each application carefully to consider who will receive funding first.



# Leukemia Texas Patient Aid Application

Complete the following form & send via mail or email.

**Please note that if the application is not legible it will not be considered.**

*Absolutely no exceptions will be made for late or incomplete applications.*

**APPLICATION DEADLINE: FRIDAY, JUNE 14, 2019 by 5PM**

**Submit your application: (faxed applications are not accepted)**

**Mail:** 4925 N O'Connor Road, Suite 125, Irving, TX 75062

**Email:** [PatientAid@leukemiatexas.org](mailto:PatientAid@leukemiatexas.org)

**WRITTEN NOTIFICATION OF THE STATUS OF YOUR APPLICATION WILL BE SENT WITHIN SIX (6) WEEKS OF THE ABOVE DEADLINE**

## Patient Information:

Male

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_

**ARE YOU A UNITED STATES CITIZEN OR LEGAL RESIDENT?.....** Yes  No

**ARE YOU A LEGAL RESIDENT OF THE STATE OF TEXAS?.....** Yes  No

Have you received financial aid from Leukemia Texas before?.....Yes  No

If yes, please note the date you last received Patient Aid: \_\_\_\_\_ (Patients are only eligible to receive aid once per 12 months)

**Insurance:** Do you have the following (check all that apply):

Medical Insurance  Prescription Drug Plan  Medicare  Medicaid  NONE

## If patient is a minor, Legal Guardian to complete:

Name(s) of Legal Guardian \_\_\_\_\_ Relationship to the Patient \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

## Attestation of Ongoing Care: \* This section must be completed and signed by Provider\*

This document is to verify that:

{Patient's Name} \_\_\_\_\_, {DOB} \_\_\_\_\_, remains under active care at our institution {Name of Care Facility} \_\_\_\_\_ {City, State} \_\_\_\_\_

for the **diagnosis** of \_\_\_\_\_, {ICD10 Code} \_\_\_\_\_. His/her treatments are continuing on a regular basis, at a frequency of {Estimated Number of Visits Per Year} \_\_\_\_\_.

**Original Date of Diagnosis:** \_\_\_\_\_

**Treatment Status (Check all that apply):**

Initial  Relapse  Maintenance  Remission  Clinical Trial/Experimental Treatment

A Patient Aid grant, up to \$1,250, is requested from Leukemia Texas for the purpose of ensuring equal access to care which includes: treatments, laboratory testing, physician examinations, counseling and psychosocial support, transportation, and housing for the patient.

**We hereby attest that this information is true and correct.**

X \_\_\_\_\_ Date \_\_\_\_\_

1st Signature: M.D., D.O., P.A., N.P.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_

2nd Signature: N.P., Social Worker, Financial Advisor, Practice Manager

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

\* Two separate signatures and contact information are REQUIRED from the Provider staff



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## **Describe the circumstance supporting your request for financial assistance: (Required)**

You may also attach additional pages if more space is needed.

Do you plan on using your assistance for any of the following (check all that apply):

Medical Bills  Mortgage/Rent  Utilities  Vehicle/Transportation  Food/Nutrition  Other  \_\_\_\_\_

Have you relocated homes due to your medical diagnosis?  YES |  NO

If YES, please provide your home address prior to treatment:

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

## **Patient Certification:**

I authorize Leukemia Texas and its agents to access and review the information I have submitted herein, including any private or confidential health information. I understand that Leukemia Texas intends to use this information in connection with their assessment of patient aid and potential payment of patient aid and will not disclose this information to third parties. This authorization expires one year from the date of submission, unless otherwise agreed.

By signing this document, I \_\_\_\_\_, hereby authorize the release of information in this application and related to my diagnosis to Leukemia Texas for the purpose of seeking financial assistance. I affirm that all of the information provided in order to qualify for financial assistance is complete and accurate. I understand that I may be denied assistance if any of the above information is false, and that I may be required to repay any assistance that I have received based on false or incomplete information.

I understand and agree that:

- (i) Leukemia Texas in its sole discretion shall determine my eligibility, participation and termination in its Patient Aid program;
- (ii) Leukemia Texas does not guarantee payment of patient aid;
- (iii) Leukemia Texas shall have no liability pursuant to my application, participation, continuation or termination in its Patient Aid program;
- (iv) I authorize my Physician to release to Leukemia Texas such medical information of mine as it may require to administer my application and participation in its Patient Aid program;
- (v) I authorize Leukemia Texas to run a background check.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

**Photo Consent: (Optional)** \*You may submit, with this application, your photograph (nonrefundable copy) for Leukemia Texas office use. Digital file is best.

By signing this document, I \_\_\_\_\_, hereby consent to the use of my attached photographic image together with my name, age, city of residence, occupation, and type of leukemia for public use by Leukemia Texas, Inc. I further release from liability and hold harmless Leukemia Texas, Inc. in the use of my image and information.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_