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The Leukemia & Lymphoma Society's
Myeloma Patient Financial Assistance Program

What is the Myeloma Patient Financial Assistance Program?
The Leukemia & Lymphoma Society's (LLS) Myeloma Patient Financial Assistance Program is available for patients affected by Myeloma to help with treatment costs, transportation, and other financial needs.
A one-time grant of $500 per patient per fiscal year (July 2016- June 2017) is available for qualified patients.
Assistance is based on available funding and the program may be discontinued at any time, without notice.

Program Criteria:

1. Be a US citizen or permanent resident living in New Jersey.
2. Have a confirmed diagnosis of Myeloma.
3. After taxes, be at or below an annual income level of 500% of Federal Poverty Guidelines (see below).

Please submit the completed application to Stacy Kreizman, Senior Patient Access Manager, by fax at 908-956-6601 or email at stacy.kreizman@lls.org.

2016 Health & Human Services Poverty Guidelines & Dollar Figures for 500% above the Federal Poverty Guidelines

Persons in Family or Household	If you live in 48 Contiguous States, Puerto Rico and D.C.	If you live in Alaska	If you live in Hawaii
	Your household income must be at or below	Your household income must be at or below	Your household income must be at or below
1	$59,400	$74,200	$68,350
2	$80,100	$100,100	$92,150
3	$100,800	$126,000	$115,950
4	$121,500	$151,900	$139,750
5	$142,200	$177,800	$163,550
6	$162,900	$203,700	$187,350
7	$183,650	$229,600	$211,150
8	$204,450	$255,600	$235,050
For each additional person add	$20,800	$26,000	$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 25, 2016
https://aspe.hhs.gov/poverty-guidelines
Adapted by The Leukemia & Lymphoma Society's Myeloma Patient Financial Assistance Program

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The Leukemia & Lymphoma Society's Myeloma Patient Financial Assistance Program - Application Form -

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

Patient Information

Patient First and Last Name: _____

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

_____

Address: _____ Apt. # _____

City/State/ZIP: _____

Country (if military): _____ Email: _____

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

How did you hear about the Myeloma Patient Financial Assistance Program?
☐ Doctor ☐ Nurse ☐ Social Worker ☐ Friend/Family Member
☐ Other (please specify): _____

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____

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

Which of these best describes your race? ☐ White or Caucasian ☐ Black or African American ☐ Asian
☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Other_____

What financial needs do you currently face (please check all that apply)?
☐ Co-Pays/Co-Insurances ☐ Insurance Premiums/Deductibles ☐ Transportation (Gas/Tolls/Parking)
☐ Rent/Mortgage ☐ Utilities ☐ Food
☐ Other (Please Explain) _____

May LLS use your answers on financial needs as data for future applications for support and other patient advocacy?*
☐ Yes ☐ No
*No confidential information will be shared. Answer in no way impacts your eligibility for this program.

Health Insurance Information

Do you currently have health insurance? ☐ Yes ☐ No If yes, please all that apply:
Medicare Part B: ☐ Medicare Part D: ☐ Medicaid: ☐ Health Exchange Plan: ☐ Commercial: ☐
Other ☐ (if other, please specify)

Name of Insurance Company (if applicable): _____

Are you currently receiving assistance from the LLS Co-Pay Assistance Program? ☐ Yes ☐ No

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Medical Information

To be completed by the patient's prescribing healthcare provider or designee. Please note, stamps 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: _____

Designee Name/Title: _____

Address: _____ City/State/ZIP: _____

Phone: ( ) _____ Healthcare Provider License #: _____

Healthcare Provider Signature: _____ Date: _____/_____/_____

Household Financial Information

Number of people in the household: _____ Is the patient/guardian currently employed? ☐ Yes ☐ No

Current annual household 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.

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

Patient/Guardian Print Name: _____

This Myeloma Patient Financial Assistance Program is provided by The Leukemia & Lymphoma Society through funds generously raised by The Philadelphia Multiple Myeloma Networking Group!

PMMNG
Philadelphia Multiple Myeloma Networking Group