

Dear Applicant,

In order to ensure a timely turnaround for processing your request for assistance, please take note of the following guidelines and facts. If you have any questions, please email Ryan Noonan at rnoonan@lazarex.org or call 925.309.8660.

Sincerely,

The Lazarex Patient Services Team

Application Guidelines and Facts

There is no guarantee of assistance when submitting this application. The application must be reviewed by Lazarex Cancer Foundation and a Patient Services Coordinator will notify the applicant of approval or denial.

We cannot accept, review or process incomplete applications. This includes the required financial information.

Complete applications are reviewed for eligibility in the order they are received.

Financial assistance is based on meeting all eligibility requirements AND on the availability of funds for our program services, which are limited.

A Lazarex Patient Services Coordinator will contact the applicant by telephone to discuss eligibility and approval. Contact is limited to two (2) attempts. The applicant is responsible for all follow up.

Please black out any social security number.

A clinical trial NCT # is required for assistance. Your Clinical Research Coordinator will be able to provide this for you on page 3 of the application.

We do not assist with expenses such as rent, mortgage, utility payments, childcare, pet care, food or insurance deductibles.

We will not reimburse any expenses that are, or will be, reimbursed by the clinical trial.

A medical representative related to your clinical trial is required to complete the third page of the application. Example: doctor, nurse, social worker, clinical trial coordinator.

The applicant may qualify for either 50%, 75% or 100% of expenses related to their clinical trial participation based on the financial information reported.

IMPACT Application for Reimbursement Assistance

New Application Re-Applying

Today's Date: _____

Applicant is:

Patient (proceed to patient information) Patient representative Name: _____

Phone Number: _____ Email Address: _____

PATIENT INFORMATION (please print clearly)

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Preferred Phone: _____

City, State, Zip: _____ Phone 2: _____

County: _____ Email Address: _____

Sex: Male Female Is the patient a U.S citizen? Yes No Does the patient have health insurance? Yes No

Does the patient speak English? Yes No Do you have a translator? If so name, relation and number? _____

Spoken Language: _____

Race / Ethnic Origin: White Black or African American Hispanic or Latino Asian or Pacific Islander American Indian or Alaskan Indian Other: (specify) _____

Emergency Contact	Relationship	Phone	Email

Treatment history to date: _____

Additional information:

Access to technology: Smart phone Computer Printer Tablet

Occupation: _____ Veteran Active Duty Reservist

If student, what grade? _____

Hobbies or talents? _____

How did you hear about us? _____

In the future, I would like to share my story, photo and experience with Lazarex Cancer Foundation. Yes No

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Fax this form to 925-552-7305 or email to Rnoonan@lazarex.org or mail to Lazarex Cancer Foundation, P. O. Box 741, Danville, CA 94526. Lazarex Cancer Foundation will review this information and contact the person requesting reimbursement assistance.

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? Yes No

FAMILY INCOME SOURCES (please check all that apply)

<input type="checkbox"/> Social Security (retirement)	<input type="checkbox"/> Salary/Wages	<input type="checkbox"/> Unemployment	<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Pension	<input type="checkbox"/> SSI
<input type="checkbox"/> SSD (disability)	<input type="checkbox"/> Short-term disability	<input type="checkbox"/> Family/friends provide support	Other: specify		

TOTAL ANNUAL FAMILY INCOME** _____ **Number of people in household:** _____

Lazarex Cancer Foundation Support Income Guidelines are set at 400% of Federal Poverty limits as follows:

Gross Family - Please evaluate your income eligibility before applying

Household #:	Income 0 -400%	Income 401% -550%	Income 551% - 700%	MUST PROVIDE INCOME INFORMATION: **
1.	\$49,960	\$49,961 - \$68,695	\$68,696 - \$87,430	Acceptable proof of income: First two pages of signed copy of income tax return OR if you do not file a tax return, copies of your most recent pay stub, unemployment check, or SSI, SSD, or public assistance benefit notification. If you are not currently employed please send a signed letter stating your current financial situation. (Please blacken out social security number)
2.	\$67,640	\$67,641 - \$93,005	\$93,006 - \$118,370	
3.	\$85,320	\$85,321 - \$117,315	\$117,316 - \$149,310	
4.	\$103,000	\$103,001 - \$141,625	\$141,626 - \$180,250	
5.	\$120,680	\$120,681 - \$165,935	\$165,936 - \$211,190	
6.	\$138,360	\$138,361 - \$190,245	\$190,246 - \$242,130	
7.	\$156,040	\$156,041 - \$214,555	\$214,556 - \$273,070	
8.	\$173,720	\$173,721 - \$238,865	\$238,866 - \$304,010	
	100%	75%	50%	

EXAMPLE: Using household of 2, approved application and expenses, customary expense caps

Up to 400% of Federal Poverty Guideline - Example: Household of 2 up to \$67,640 receives 100% of approved expenses reimbursed:
 Between 401% and 550% of Federal Poverty Guideline - Example: Household of 2 between \$67,641 and \$93,005 receives 75% reimbursed of approved expenses
 Between 551% and 700% of Federal Poverty Guideline - Example: Household of 2 between \$93,006, and \$118,370 receives 50% reimbursement of approved expenses
 See more at: <https://aspe.hhs.gov/poverty-guidelines>

****Application will not be processed if this information is not provided****

FINANCIAL ASSISTANCE NEEDS (please check all that apply)

<input type="checkbox"/> Taxi/Uber/Lyft	<input type="checkbox"/> Train	<input type="checkbox"/> Hotel/Motel	<input type="checkbox"/> Rental Car	<input type="checkbox"/> Car/Boat Service
<input type="checkbox"/> Parking	<input type="checkbox"/> Tolls	<input type="checkbox"/> Bus/Subway	<input type="checkbox"/> Scans/Labs <small>No copays or deductibles</small>	<input type="checkbox"/> Travel Companion <small>Ex: Companion flight</small>
<input type="checkbox"/> Flights	Airport traveling from _____ to _____		Approximate economy flight price _____	
<input type="checkbox"/> Gas @ \$0.18 per mile	How many round trip miles from home to clinical trial location? _____			

Please be aware that funds are limited, and will be granted based on availability as well as meeting Lazarex Cancer Foundation's eligibility requirements.

We do not assist with living expenses such as rent, mortgage, utility payments, childcare, pet care or food. We do not reimburse for expenses related to insurance deductibles. We do not assist with expenses prior to approval.

Signature of Patient or Patient Representative: _____ **Date:** _____

I attest by way of my signature that any financial grants which may be awarded will be used as reimbursement for expenses above.

Your relationship to person applying for help: Self Spouse Family Member Friend Health care professional

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THIS SECTION MUST BE COMPLETED BY YOUR MEDICAL REPRESENTATIVE ONLY
(ONCOLOGIST NURSE, DOCTOR, SOCIAL WORKER OR CLINICAL TRIAL COORDINATOR , etc.)

Patient Name: _____

MEDICAL INFORMATION (please print clearly)

Primary Cancer and Stage of Cancer:

Clinical Trial Doctor: _____

Clinical Trial Clinic/Hospital: _____

Clinical Trial Address: _____

City, State, Zip: _____

Phone Number: _____

Email Address: _____

Clinical Trial Sponsor Company:

**Clinical Trial Name:
NCT #
(Required for assistance)**

Phase of Clinical Trial: Phase 1 Phase 2 Phase 3 Phase 4

Is patient currently receiving financial reimbursement from clinical trial?

Yes No

**Treatment Schedule:
(EX: 3 weeks on 3 weeks off)**

If yes, what type?

NAME AND TITLE OF MEDICAL REPRESENTATIVE COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE:
(please print clearly)

Name: _____

Title: _____

Direct Phone Number: (no general #'s) _____

Email Address: _____

Signature of Medical Representative: _____ **Date:** _____

Your relationship to person applying for help: Doctor Nurse Social Worker CT Coordinator Other: _____

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