Lazarex
CANCER FOUNDATION

P O Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
www.lazarex.org
REV08082019

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.

Lazarex Care 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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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)

☐ Social Security (retirement)	☐ Salary/Wages	☐ Unemployment	☐ Public Assistance	☐ Pension	☐ SSI
☐ SSD (disability)	☐ Short-term disability	☐ 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%
1.	$49,960	$49,961 - $68,695	$68,696 - $87,430
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%

MUST PROVIDE INCOME INFORMATION: **

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***)

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 $67,641and $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)

☐ Taxi/Uber/Lyft	☐ Train	☐ Hotel/Motel	☐ Rental Car	☐ Car/Boat Service
☐ Parking	☐ Tolls	☐ Bus/Subway	☐ Scans/Labs No copays or deductibles	☐ Travel Companion Ex: Companion flight

☐ Flights — Airport traveling from ______ to ______ Approximate economy flight price ______

☐ 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

If yes, what type?

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

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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Lazarex Cancer Foundation is committed to the principles of equal access to services. Lazarex prohibits discrimination against any person on the basis of race, color, national origin, age, disability, sexual orientation, gender or gender expression, marital, familial, or parental status, religion, genetic information, military status, political beliefs, or any other status protected under local, state, or federal law, in connection with its programs and activities. This policy extends to all personnel decisions, terms and conditions of employment, vendor contracts, and the provision of services. We are committed to providing an inclusive and welcoming environment for all members of our staff, volunteers, subcontractors, vendors, and patients. Lazarex Cancer Foundation is a 501 (c)(3) non-profit organization. Our tax identification number is 20-2562494.