Lazarex CANCER FOUNDATION IT'S ABOUT LIVING | Creating Access Care Reimbursing Expenses

P O Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
www.lazarex.org
Rev 312020

Dear Applicant,

Thank you for contacting Lazarex Cancer Foundation. It is our mission to connect cancer patients to clinical trials so you can continue to stay engaged in your fight against cancer. *Therefore we provide financial reimbursement for out of pocket travel expenses associated with clinical trial participation.* 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 925.820.4517.

Sincerely, The Lazarex Patient Services Team

APPLICATION GUIDELINES AND FACTS

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

Due to the volume of applications received 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.

In any document you send to us please black out any social security number.

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 sponsor.

A medical representative at your clinical trial location is required to complete the page of the application titled Medical Information Form and provide the NCT # (National Clinical Trial) that is required for assistance. Example: doctor, nurse, social worker, clinical trial coordinator.

Financial assistance is based on meeting all Lazarex Cancer Foundation eligibility requirements AND on the availability of funds for our program services.

The applicant may qualify for either 50%, 75% or 100% of expenses related to their clinical trial participation based upon reported household income as defined by the income guidelines on the next page. 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.

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INCOME GUIDELINES

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.	$51,040	$51,041 - $70,180	$70,181 - $89,320	**Acceptable proof of income:** First two pages of signed copy of income tax return OR If you do not file a tax return, a copy 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.	$68,960	$68,961 - $94,820	$94,821 - $120,680	
3.	$86,880	$86,881 - $119,460	$119,461 - $152,040	
4.	$104,800	$104,801- $144,100	$144,101 - $183,400	
5.	$122,720	$122,721- $168,740	$168,741 - $214,760	
6.	$140,640	$140,641 - $193,380	$193,381 - $246,120	
7.	$158,560	$158,561 - $218,020	$218,021 - $277,480	
8.	$176,480	$176,481- $242,660	$242,661 - $308,840	
	100%	**75%**	**50%**	

Application will not be processed if this information is not provided

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 $68,960 receives 100% of approved expenses reimbursed

Between 401% and 550% of Federal Poverty Guideline
Example: Household of 2 between $68,961 and $94,820 receives 75% reimbursed of approved expenses

Between 551 % and 700% of Federal Poverty Guideline
Example: Household of 2 between $94,821 and $120,680 receives 50% reimbursement of approved expenses

See more at: https://aspe.hhs.gov/poverty-guidelines

FOR LCF STAFF USE ONLY

Date Received:

Date of Approval:

Reimbursement Allowance %

LAZAREX APPLICATION FOR REIMBURSEMENT ASSISTANCE

☐ New Application ☐ Re-Applying Today's Date: ______________________

Applicant is:

☐ Patient (proceed to patient information) ☐ Patient representative - Name: ______________________

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

Phone Number: ______________________ Email Address: ______________________

PATIENT INFORMATION (please print clearly)

Patient Name: ______________________ Date of Birth: __________ Age: ______

Address: ______________________ Preferred Phone: ______________________

City, State, Zip: ______________________ Alternate Phone: ______________________

County: ______________________ Email Address: ______________________

What sex were you assigned at birth on your original birth certificate: ☐ Male ☐ Female

Does the patient speak English? ☐ Yes ☐ No

What is the preferred language for communications with Lazarex? ______________________

Do you have a translator? ☐ Yes ☐ No

Translator Name: ______________________

Relation: ______________________

Phone Number: ______________________

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

You are not guaranteed assistance by submitting this application. Incomplete applications cannot be accepted.

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EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Relationship	Phone	Email

TREATMENT INFORMATION

Treatment history to date:

REFERRAL INFORMATION

How did you hear about us?

- ☐ Another Patient
- ☐ Doctor/Nurse/Trial Coordinator
- ☐ Family/Friends
- ☐ Medical Facility
- ☐ News/Media/Internet
- ☐ Social Worker
- ☐ Other Organization
- ☐ Events
- ☐ Other (please specify)

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INSURANCE INFORMATION

Does the patient have health insurance? ☐ Yes ☐ No

Insurance Type: ☐ Medicaid-Managed Care ☐ Medicaid-State ☐ Medi-CAL ☐ Private/Commercial ☐ Tricare
☐ Medicare Standard ☐ Medicare-Advantage ☐ Other (please specify)

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ☐ Yes ☐ No Place of Employment: ______________________

FAMILY INCOME SOURCES (please check all that apply)

☐ Social Security (retirement) ☐ Salary/Wages ☐ Pension ☐ Unemployment ☐ Public Assistance ☐ SSI

☐ SSD (disability) ☐ Short-term disability ☐ Family/friends provide support ☐ Other (please specify):

TOTAL ANNUAL FAMILY INCOME**	Number of people in household:
Application will not be processed if this information is not provided	

FINANCIAL ASSISTANCE REQUESTS (please check all that apply)

☐ Ground Transportation (Uber, Taxi, Lyft, Rental, Train) ☐ Mileage / Parking / Tolls ☐ Patient Lodging ☐ Companion Lodging

☐ Patient Air Travel ☐ Companion Air Travel ☐ Other (please specify):

Airport traveling from ______________ to ______________ Approximate economy flight price: ______________

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.

Printed Name of Patient or Patient Representative: ______________________ Date: ______________

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.

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ADDITIONAL INFORMATION (optional)

The following set of questions are for statistical purposes to be used only by Lazarex and will not affect whether the patient receives reimbursement from Lazarex Cancer Foundation.

What is the highest degree or level of school you have completed?

☐ Less than a high school diploma ☐ High school degree or equivalent ☐ Bachelor's degree ☐ Master's degree

☐ Doctorate (e.g. PhD, EdD) ☐ Other: (please specify) ☐ Student - if student, what grade? ____________

If comfortable sharing, what Faith do you follow?

Access to technology: ☐ Computer ☐ Smart phone ☐ Tablet ☐ Printer

Occupation: ☐ Veteran ☐ Active Duty ☐ Reservist

Hobbies or talents?

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

Is the patient a U.S citizen? ☐ Yes ☐ No

Do you think of yourself as:

☐ Male ☐ Female ☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Decline to Answer

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male nor female

☐ Additional gender category/ (or Other), please specify: ____________

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.

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.

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MEDICAL INFORMATION FORM

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

Patient Name:

Primary Cancer: **Primary Cancer Stage:**

Clinical Trial Doctor / PI:

Direct Phone Number of Doctor / PI: **Email Address:**

Clinical Trial Clinic/Hospital:

Clinical Trial Address:

City, State, Zip:

Clinical Trial Sponsor Company:

Clinical Trial NCT #:
(Required for assistance)

Clinical Trial Name:

Phase of Clinical Trial: ☐ Phase I ☐ Phase II ☐ Phase III ☐ Phase IV ☐ Phase I/II ☐ Phase II/III ☐ Phase III/IV

Is patient currently receiving financial reimbursement from clinical trial sponsor? ☐ Yes ☐ No

If yes, how much and what for?

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

NAME AND RELATION OF CLINICAL TRIAL REPRESENTATIVE COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE: (please print clearly)

Name:

Direct Phone Number: (no general #s) Email Address:

Signature of Clinical Trial Representative: ______________________ Date: __________

Your relationship to person applying for help: ☐ Doctor ☐ Nurse ☐ Social Worker ☐ CT Coordinator ☐ Other (please specify): __________

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