

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.

INCOME GUIDELINES

Lazarex Cancer Foundation Support Income Guidelines are set at 700% 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)

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)

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.

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.

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

Phase I

Phase II

Phase III

Phase IV

Phase I/II

Phase II/III

Phase III/IV

Clinical Trial: _____

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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