Creating Access Care Reimbursing Expenses | Lazarex CANCER FOUNDATION www.lazarex.org

P.O. Box 741 Danville, CA 94526
Phone: 925-820-4517 Fax: 925-552-7305
www.lazarex.org
FORM: CA-AIQ REV: 013123

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.

We are here to help you with this application process. If you have any questions, please email patientservices@lazarex.org or call 925.820.4517.

Sincerely, The Lazarex Patient Services Team

APPLICATION GUIDELINES AND FACTS

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

Based upon adjusted gross household income, the applicant may qualify for either 50%, 75%, or 100% of out-of-pocket travel expenses related to their clinical trial participation up to the associated monthly maximum. Please see the income guidelines on the next page. A Lazarex Patient Services Coordinator will contact the applicant by telephone to discuss their level of eligibility and approval. Contact is limited to two (2) attempts. The applicant is responsible for providing all required information.

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

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

Due to the volume of applications we receive, we can only accept, review, and process complete applications. This includes the required financial information. The last page of this application is the “Medical Information Form” which is to be completed after the applicant has been accepted into a clinical trial by a medical representative. Example: doctor, nurse, social worker, clinical trial coordinator, etc. The completed form with a medical representatives signature must be submitted to Lazarex Cancer Foundation to complete enrollment in the program and begin the reimbursement process.

Submitted and complete applications will be reviewed by Lazarex and a Patient Services Coordinator will notify the applicant of approval status. **PRE-APPROVAL** notification will be provided to applicants who meet financial eligibility requirements and who are waiting to be enrolled in a clinical trial. **APPROVAL** will be provided to applicants who meet financial eligibility requirements and who are already accepted into or are already participating in a trial.

Lazarex Cancer Foundation will provide the approved applicant with an agreement to be reviewed and signed, and a travel log that will be completed monthly and returned to Lazarex along with the receipts that verify out-of-pocket expenses for reimbursement. Reimbursements are provided monthly to approved applicants via a debit card.

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

Please cross out social security numbers that appear on any document you send to us.

INCOME GUIDELINES

Lazarex Cancer Foundation Expense Reimbursement Eligibility is set at 700% of the 2023 Federal Poverty Guidelines (FPG) as follows Adjusted Gross Household Income - Please evaluate your income eligibility before applying

# Household Members	Total Adjusted Gross Household Income up to 400% FPG	Total Adjusted Gross Household Income between 401% - 550% FPG	Total Adjusted Gross Household Income between 551% - 700% FPG	MUST PROVIDE INCOME INFORMATION**
1	$58,320	$58,321 - $80,190	$80,191 - $102,060	**Acceptable Proof of Income:** First two pages of signed income tax return OR if you do not file a tax return, a copy of your most recent paystub, unemployment check, SSI or SSD, or public assistance benefit notification. If you are not currently employed please send a signed letter stating your current financial situation.
2	$78,880	$78,881 - $108,460	$108,461 - $138,040	
3	$99,440	$99,441 - $136,730	$136,731 - $174,020	
4	$120,000	$120,001 - $165,000	$165,001 - $210,000	
5	$140,560	$140,561 - $193,270	$193,271 - $245,980	
6	$161,120	$161,121 - $221,540	$221,541 - $281,960	
7	$181,680	$181,681 - $249,810	$249,811 - $317,940	
8	$202,240	$202,241 - $278,080	$278,081 - $353,920	
Eligibility %	100%	75%	50%	**(Please cross out Social Security Number)**
Monthly Maximums	Up to $1,500	Up to $1,125	Up to $750	

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

EXAMPLE: Using household of 2, approved expenses and maximum monthly reimbursement will be:

Up to 400% of Federal Poverty Guideline
Example: Household of 2 with income up to $78,880 receives reimbursement of 100% of approved submitted expenses up to $1500 per month maximum

Between 401% and 550% of Federal Poverty Guideline
Example: Household of 2 with income between $78,881 and $108,460 receives reimbursement of 75% of approved submitted expenses up to $1125 per month maximum

Between 551% and 700% of Federal Poverty Guideline
Example: Household of 2 with income between $108,461 and $138,040 receives reimbursement of 50% of approved submitted expenses up to $750 per month maximum

APPLICATION STATUS EXPLANATION

Pre-Approval status is provided to patients who apply for travel expense reimbursement, meet our eligibility requirements, and who are in the process of clinical trial consent but who haven't been accepted into a trial yet. We provide pre-approval for the well-being of patients so they can make a decision about clinical trial participation without having to worry about covering the out-of-pocket expenses for travel. Once a patient has been accepted into a clinical trial a Medical Information form (last page of this application) must be submitted to Lazarex Cancer Foundation in order to receive approval status.

Approval status is provided to patients who apply for travel expense reimbursement, meet our eligibility requirements, and who have already been accepted into a clinical trial or are already participating in a clinical trial. When a patient receives Approval status, they will be provided with a Patient Agreement that outlines the reimbursement process, approved travel expenses, and the monthly maximum reimbursement amount.

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FOR LCF STAFF USE ONLY

Date Received:
Date of Pre-Approval:
Date of Approval:
Reimbursement Allowance %:

APPLICATION FOR CLINICAL TRIAL TRAVEL EXPENSE REIMBURSEMENT

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

Date received by Lazarex Staff: _____

Applicant is:

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

Your relationship to patient: ☐ 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 was patient assigned at birth on the original birth certificate: ☐ Male ☐ Female

Does the patient speak English? ☐ Yes ☐ No

What is the preferred language for communications with Lazarex? _____

Does the patient have a translator? ☐ Yes ☐ No

Translator Name: _____

Relation: _____ Phone Number: _____

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

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

Occupation: ☐ Veteran ☐ Active Duty ☐ Reservist

Hobbies or talents?

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

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Relationship	Phone	Email

HEALTH HISTORY

Previous Cancer Treatment: (check all that apply)

Chemotherapy: Yes ☐ No ☐ If yes how many types of chemotherapy: _____

Radiation: Yes ☐ No ☐ Surgery: Yes ☐ No ☐

Immunotherapy: Yes ☐ No ☐ Targeted Therapy: Yes ☐ No ☐

Hormone Therapy: Yes ☐ No ☐ Previous Clinical Trial: Yes ☐ No ☐

Other Chronic Diseases: (check all that apply)

Heart Disease:	Yes ☐	No ☐	History of Liver Disease (not related to cancer):	Yes ☐	No ☐
Chronic Kidney Disease:	Yes ☐	No ☐	Chronic Lung Disease (Asthma COPD):	Yes ☐	No ☐
Stroke:	Yes ☐	No ☐	Alzheimer's Disease or Dementia:	Yes ☐	No ☐
Hypertension (High Blood Pressure):	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
High Cholesterol:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
Diabetes:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐
Heart Attack:	Yes ☐	No ☐	On Medication:	Yes ☐	No ☐

REFERRAL INFORMATION

How did the patient hear about us?

☐ Another Patient ☐ Doctor/Nurse/Trial Coordinator ☐ Family/Friends ☐ Medical Facility

☐ News/Media/Internet ☐ Social Worker ☐ Events

☐ Other Organization (please specify): _____

☐ 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: _____

HOUSEHOLD 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 HOUSEHOLD 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 co-pays or 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: _____

ADDITIONAL INFORMATION (optional)

The following set of questions are for use only by Lazarex Cancer Foundation to help us serve partients better and will not affect enrollment in the program.

What is the highest degree or level of school the patient has completed?

☐ Less than a high school diploma ☐ High school degree or equivalent ☐ Bachelor's degree (e.g. BA, BS) ☐ Master's degree (e.g. MA, MS, MEd)

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

Does the patient identify 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: _____

If comfortable sharing, what Faith does the patient follow?

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

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

So we may better understand the needs of our patients and improve our level of service, would the patient be willing to participate in simple surveys in the future? ☐ Yes ☐ No

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Lazarex Cancer Foundation is committed to the principles of equitable 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, immigration status, 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.

Fax this form to 925-552-7305 or email to patientservices@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.

MEDICAL INFORMATION FORM

AFTER THE APPLICANT HAS BEEN ACCEPTED INTO A CLINICAL TRIAL, THIS SECTION MUST BE COMPLETED AND SIGNED BY YOUR CLINICAL TRIAL MEDICAL PROFESSIONAL (ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER, CLINICAL TRIAL COORDINATOR, ETC.).

THIS FORM MUST BE RETURNED TO LAZAREX CANCER FOUNDATION TO COMPLETE ENROLLMENT IN THE PROGRAM AND BEGIN THE REIMBURSEMENT PROCESS.

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, is this a stipend for participation? ☐ Yes ☐ No Amount: _____ ☐ One time only ☐ Every visit # of payments/frequency: _____

Is this a reimbursement for travel expense? ☐ Yes ☐ No ☐ One time only ☐ Every visit

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

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

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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