Bone Marrow & Cancer FOUNDATION

515 MADISON AVENUE, SUITE 1130
NEW YORK, NY 10022
212-838-3029
800-365-1336
PATIENTSERVICES@BONEMARROW.ORG

LIFELINE FUND APPLICATION

Please read the Lifeline Fund Guidelines carefully before completing this form.

PATIENT INFORMATION

First Name _____ Last Name _____

Date of Birth _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

Responsible Family Member _____

Relationship to Patient _____

Email _____

Phone _____

Check Payable To _____

Send Check To _____

Address _____

City _____ State _____ Zip _____

Preferred Language ☐ English ☐ Spanish ☐ Other – specify: _____

Race/Ethnicity (optional)
☐ Hispanic/Latino ☐ African American/Black
☐ Native American ☐ White/Non-Hispanic
☐ Asian ☐ Other – specify: _____

Are you a veteran? ☐ Yes ☐ No

I would like information about the programs selected below.

Additional Financial Assistance Programs
☐ Carelines Funds – personalized fundraising accounts
☐ Scholarship Grant – program available to students

Support Programs
☐ Ask the Expert – Advice from transplant professionals
☐ SupportLine – Patient-to-patient peer support
☐ Survivorship Telephone Support Group
☐ Clinical Care Counseling – confidential counseling

I certify I have read and understand the Lifeline Fund Guidelines and I agree to abide by these guidelines.

_____ _____
Patient/Responsible Family Member's Signature Date

PHYSICIAN AND NURSE INFORMATION

Complete diagnosis _____

Date/expected date of BMT _____

Hospital _____

Physician _____

Email _____ Phone _____

Nurse Coordinator _____

Email _____ Phone _____

Type of Transplant (check all that apply)
☐ Autologous ☐ Bone marrow
☐ Allogeneic, related ☐ Stem cell
☐ Allogeneic, unrelated ☐ Cord blood

TO BE COMPLETED BY SOCIAL WORKER/NURSE COORDINATOR (CONTINUED ON PAGE 2)

Social Worker/Nurse _____

Hospital _____

Address _____

City _____ State _____ Zip _____

Email (required) _____

Phone (required) _____

Is this the first request to the Lifeline Fund/Patient Aid? ☐ Yes ☐ No

If not, when was previous request? _____

_____ _____
Social Worker/Nurse's Signature Date

Aid received or pending from other organization _____

_____

Continue on page 2

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TO BE COMPLETED BY SOCIAL WORKER/NURSE COORDINATOR (CONTINUED FROM PAGE 1)

Patient's current medical, living, family and financial situation. Feel free to attach an additional page or letter if necessary.

_____

_____

_____

_____

_____

_____

Service Request – Rank up to three areas of greatest need and provide additional details.

____ Transportation ____ Housing

____ Co-pays/Premiums ____ Utilities

____ Medical Expenses ____ Caregiver

____ Living Expenses ____ Donor Costs

____ Other – specify: _____

TO BE COMPLETED BY PATIENT AND SOCIAL WORKER/NURSE COORDINATOR

Employment – Indicate any upcoming changes in employment.

_____

_____

_____

_____

_____

Financial Info – Do not leave any fields blank. If value is zero, write $0.00. If household income is listed as zero, please explain in Psychosocial Summary.

Estimated Monthly Household Revenue			
Income	$	Disability	$
Unemployment	$	Pension	$
Social Security	$	Other	$

Estimated Monthly Household Expenses			
Rent/Mortgage	$	Utilities	$
Medical Insurance	$	Transportation	$
Outstanding Expenses	$	Medical Expenses	$
Caregiver Expenses	$	Other	$

Household Savings	
Savings Account	$

Patient's Insurance _____

Number of household members _____

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LIFELINE FUND GUIDELINES

Please read the Guidelines carefully before completing this form.

ABOUT LIFELINE FUND

As the Bone Marrow & Cancer Foundation's flagship program, The Lifeline Fund provides financial support to individuals who meet our eligibility guidelines. This funding helps to cover the myriad costs associated with transplants, such as donor searches, compatibility testing, bone marrow harvesting, medications, home and child care services, medical equipment, transportation, cord blood banking, and housing.

In order to be considered for this program, patients must be affiliated with a certified transplant center and must be on track to have a bone marrow, stem cell, or cord blood transplant or s ill be receiving post-transplant care.

LIFELINE FUND GUIDELINES

All sections of the application, including the nurse coordinator's or social worker's signature, must be completed before being considered for evaluation. Incomplete applications will not be accepted.

Social Worker/Nurse Coordinator

In order to understand the nature of the patient's need and properly evaluate the application, please be as specific as possible when completing the application and consider all members of the household when completing the financial information. If necessary, feel free to attach an additional page for this information. It is not necessary to submit receipts or financial records.

The Psychosocial Summary section should describe additional factors beyond the financial information to be considered during the evaluation process (e.g. length of time unemployed, health concerns of another family member, other significant expenses, etc.). The Service Request section should explain the assistance requested, with specified amounts for each if possible (ex. $150 for gas, $325 for insurance premium, etc.).

TYPE OF ASSISTANCE

Lifeline funding may be requested to cover costs associated with:

- donor search, testing and related expenses
- medical treatment
- health insurance premiums and co-pays
- medication and medical supplies
- home and day care
- transportation
- accommodations
- psychosocial support
- sperm banking
- cord blood banking
- legal fees
- living and housing expenses (ex. rent, utilities, groceries, etc.)
- caregiver expenses related to transplant

For questions about other expenses, contact the Bone Marrow & Cancer Foundation.

EVALUATION AND DECISIONS

All requests are acknowledged via email upon time of receipt to the patient as well as to the social worker or nurse indicated on the form. The social worker and patient will also be contacted once a decision has been reached.

As funding is limited for the Lifeline Fund, priority for grants is given to patients meeting eligibility guidelines and demonstrating the greatest financial need. Patients who are approved will receive a one-time grant.

Patients whose initial request is declined may reapply if there is a change in their socioeconomic status. Patients reapplying must complete a new application.

DISBURSEMENT OF FUNDS

Patient funding will be disbursed within 4-6 weeks of receipt of the application. Funds will be disbursed only in the form of a check from the Bone Marrow & Cancer Foundation and made payable to the individual or entity listed on the application.

The Bone Marrow & Cancer Foundation reserves the right to deviate from these Guidelines on a case-by-case basis when special circumstances arise.