Bone Marrow & Cancer FOUNDATION
NAVIGATING ALL CANCERS TOGETHER

515 MADISON AVENUE, SUITE 1130
NEW YORK, NY 10022
212-838-3029
HAP@BONEMARROW.ORG

HOUSING ASSISTANCE PROGRAM (HAP) APPLICATION

Please read the HAP Guidelines carefully before completing the application.

PATIENT INFORMATION

Pediatric: ☐ Adult: ☐ Date of Birth _____ Age _____ Gender _____

Are you a veteran? ☐ Yes ☐ No ☐ I choose not to self-identify

First Name _____ Last Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Email _____
**Please use your Airbnb email if a registered user*

Caregiver's Name _____ Relationship to Patient _____

Caregiver's Phone _____ Caregiver's Email _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

HAP HOUSING REQUEST INFORMATION

Housing for: ☐ Patient only ☐ Patient and Caregiver/Family Member(s) ☐ Caregiver/Family Member(s) only

Reservation Booked by: ☐ Patient ☐ Caregiver ☐ Family Member/Friend E-mail _____

Requested Arrival Date _____ Anticipated Departure Date _____ Number of Nights Requested _____

City/Neighborhood _____ State _____ Zip _____

Number of Guest(s) _____ Age(s) of Guest(s) _____ Number of Room(s) Requested _____

PATIENT TREATMENT

Diagnosis _____ Date of Diagnosis _____

Type of Cancer Treatment: ☐ Chemo ☐ Radiation ☐ BMT ☐ Other-Specify: _____

Treatments: ☐ Weekly ☐ Daily ☐ Other-Specify: _____ ☐ Inpatient ☐ Outpatient

Treatment Start Date _____ Treatment End Date _____ Enrolled in a clinical Trial? ☐ Yes ☐ No

Hospital _____ Department _____

Physician _____ Email _____ Phone _____

Nurse _____ Email _____ Phone _____

Social Worker _____ Email _____ Phone _____

PATIENT INCOME

Please do not leave any field blank. If a value is zero, write $0.00. Please provide the applicant's most recent IRS Form 1040 and of other family member(s), if he/she has a combined income.

Current Household Income (Annually) _____ Current Household Savings _____

Expected Change in Income _____ Number of Household Members _____

Patient's Insurance _____

REFERRAL INFORMATION *PHYSICIAN, NURSE, SOCIAL WORKER, CASE MANAGER, NAVIGATOR

Name of Referring Professional _____ Title _____

Hospital _____ Department _____

Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

Signature of Referring Professional _____ Date _____

STATEMENT OF NEEDS

Patient's current medical, living, family and financial situation. Please include an additional page or letter if necessary.

_____

_____

_____

_____

☐ YES, I would like to receive information on other Bone Marrow & Cancer Foundation's patient financial and support programs.

GENERAL QUESTIONS

Does the patient or caregiver need a wheelchair-accessible room? ☐ Yes ☐ No

Is the patient/caregiver able to navigate stairs? ☐ Yes ☐ No

Please list any other relevant special needs: _____

Does the patient or caregiver have a service animal? ☐ Yes ☐ No

Does the patient or caregiver require pet-friendly accommodations? ☐ Yes ☐ No

Does the patient or caregiver require available parking? ☐ Yes ☐ No

Does the patient or caregiver require smoking-friendly accommodations? ☐ Yes ☐ No

Would the patient like to meet the host/family? ☐ Yes ☐ No

Is the patient willing to share their story, so that more hosts and families donate their home? ☐ Yes ☐ No

Does the patient have any infectious diseases or infectious-disease symptoms? ☐ Yes ☐ No

Does the caregiver have any infectious diseases or infectious-disease symptoms? ☐ Yes ☐ No

Has the patient ever been convicted of a crime of violence, domestic violence, a crime against a child, a crime of theft, or a crime involving drugs? ☐ Yes ☐ No

Has the caregiver ever been convicted of a crime of violence, domestic violence, a crime against a child, a crime of theft, or a crime involving drugs? ☐ Yes ☐ No

Is the patient currently on probation or parole? ☐ Yes ☐ No

Is the caregiver currently on probation or parole? ☐ Yes ☐ No

Does the patient have a civil protection order against him/her? ☐ Yes ☐ No

Does the caregiver have a civil protection order against him/her? ☐ yes ☐ No

Is the patient required to register on a state or the National Sex Offender Registry? ☐ Yes ☐ No

Is the caregiver required to register on a state or the National Sex Offender Registry? ☐ Yes ☐ No

If answered YES to any of these questions please explain below:

_____
_____
_____
_____

REFERRING PROFESSIONAL'S STATEMENT

As the referring source, I have reviewed the Bone Marrow & Cancer Foundation's guideline and eligibility requirements with the patient and attest that all responses are accurately recorded on this form.

_____

Referring professionals name (please print) _____

Signature_____ Date_____

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HOUSING ASSISTANCE PROGRAM (HAP) GUIDELINES

Please read the below HAP Guidelines carefully before completing the application.

ABOUT HOUSING ASSISTANCE PROGRAM (HAP)

Our program provides free temporary housing to cancer/ transplant patients, caregivers, and donors while receiving lifesaving treatment. Any patient, pediatric or adult, who lives at least 30 miles away from his/her treatment facility is eligible to apply. The Bone Marrow & Cancer Foundation is not liable for any guest's health condition, individual safety, or personal belongings. Transportation and other associated costs are not provided.

All patients who are receiving treatment for a cancer diagnosis or continuously getting post care by a certified cancer center are welcomed to our program. Referring healthcare professionals may make a referral by completing the *Bone Marrow & Cancer Foundation Housing Assistance Program Application.* The referrer may email the application to hap@bonemarrow.org.

HOUSING ACCOMODATIONS

Patients and any accompanying family members/friends may receive up to two weeks of housing assistance through Airbnb, either consecutively or intermittently. Extended stays may be accommodated if medically necessary. Please note that patients may need to move to a different home.

STATEMENT OF NEEDS

We encourage the referrer to be specific of the needs of the patient as much as possible. When necessary, feel free to attach an additional page.

ELIGIBILITY REQUIREMENTS FOR PATIENTS

- Must live at least 30 miles from treatment center.
- Must be seeking or receiving active cancer treatment.
- Must have a permanent home to return to after treatment.
- Must be at least 18 years of age or accompanied by an adult who is a guardian/caregiver.
- Must be able to care for oneself unless staying with a caregiver.
- Requests for housing assistance stays must be made by the treatment facility's healthcare professional team member (e.g., social worker, nurse, physician, case manager, navigator, etc.).
- Annual household income should be less than $75,000.

APPLICATION REQUIREMENTS

- Referrer, on behalf of patient, may submit a completed application by email to hap@bonemarrow.org.
- Applicant's current IRS Form 1040 is required.

Applicant will be notified of eligibility within 2 weeks from the date of application received by the Bone Marrow & Cancer Foundation.

For questions about the Housing Assistance Program or if the patient needs assistance, please contact the Bone Marrow & Cancer Foundation at hap@bonemarrow.org or 212-838-3029.

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