NATIONAL MARROW DONOR PROGRAM® BE THE MATCH®

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# Drs. Jeffrey and Isabel Chell Clinical Trials Travel Grant

With funding from Be The Match Foundation®, the National Marrow Donor Program®/Be The Match® provides financial help for patients (blood disorders/cancers), who need help paying the cost to travel for clinical trials. The **Drs. Jeffrey and Isabel Chell Clinical Trials Travel Grant**, in partnership with the *Jason Carter Clinical Trials Program*, helps qualified patients with the following travel costs:

- Patient and companion air travel: booked by dedicated travel agents
- Ground transportation: Gas/parking, and public/mass transit (bus/train/cab/etc.)
- Accommodations: hotel, temporary housing and incidentals

## Eligibility Requirements

- Patient must live in the United States (either resident or citizen).
- Patient has been diagnosed with a blood disorder or blood cancer, for which a clinical trial is a primary or independent treatment focus at this time.
- Medical team confirms clinical trial eligibility and planned participation, and submits application.
- Trial is included in the *Jason Carter Clinical Trials Program:* Jasoncarterclinicaltrialsprogram.org
- Meets minimum travel cost requirements (see question 5 below).
- Household monthly net (take-home) income is within the income limits shown in this table:

| # of persons in household | All states (except AK & HI), PR and DC | Alaska | Hawaii |
|---|---|---|---|
| 1 | $3,015 | $3,765 | $3,465 |
| 2 | $4,060 | $5,073 | $4,668 |
| 3 | $5,105 | $6,380 | $5,870 |
| 4 | $6,150 | $7,688 | $7,073 |
| Each additional person | $1,045 | $1,307 | $1,203 |

**To see if the patient is likely to be eligible, answer these questions before completing the application*:**

1. Does the patient have a blood disorder or blood cancer? ☐ **Yes** ☐ **No**
2. Is the patient's household income within the limits in the table above? ☐ **Yes** ☐ **No**
3. Is the patient enrolled in, or in the process of enrolling in, a clinical trial? ☐ **Yes** ☐ **No**
4. Is the clinical trial listed in the Jason Carter website? ☐ **Yes** ☐ **No**
5. Is at least one of the statements below true about the patient's travel needs? ☐ **Yes** ☐ **No**
   a. Has to fly to get to the clinical trial.
   b. Has to drive/be driven more than 300 miles a month for the clinical trial.
   c. Costs $150+ a month on bus/train/cab/parking etc. for the trial.
   d. Costs $150+ a month on accommodations (hotel, food etc.) for the trial.
6. Will someone on the medical team affirm patient need and submit application? ☐ **Yes** ☐ **No**
7. Does patient meet all the qualifications listed in the eligibility section? ☐ **Yes** ☐ **No**

***If you answered "No" to any of the questions you *might not* be eligible. However, answering "Yes" isn't a guarantee of eligibility - it is only an indication that you most likely are eligible. Patients and families should talk to their medical team, or contact Patient Support Center at 888-999-6743 or patientinfo@nmdp.org with questions.**

- If you have government benefits (Medicaid, SSI etc.), make sure this grant won't negatively affect them.
- Air travel services are booked by a separate and independent vendor. NMDP doesn't operate, control, or provide services of the vendor. Hence, grant awardee agrees that NMDP isn't responsible for loss, accident, injury, delay, defect, omission or irregularity which may occur, whether because of any act, negligence or default of any company or person engaged in, responsible for, or connected to travel arrangements.
- Availability of grant depends on funding. Grant approval isn't guaranteed, regardless of eligibility.

**Complete application thoroughly; missing information will cause delays or denial.**

## A. Patient Information

| | | |
|---|---|---|
| Name (as it appears on legal ID): | | |
| Address: | | |
| Parent/guardian name (pediatric patients): | | |
| DOB: | Sex: ◯ **Male** ◯ **Female** | Does patient live in the U.S.? ◯ **Yes** ◯ **No** |

| | |
|---|---|
| **Race**<br>☐ American Indian or Alaska native ☐ Asian ☐ Black<br>☐ Native Hawaiian or other Pacific Islander ☐ White<br>☐ Other: | **Ethnicity**<br>◯ Hispanic ◯ Not Hispanic |

| | |
|---|---|
| Phone#: | Email: |
| Diagnosis: | |

## B. Clinical Trial Information

| | |
|---|---|
| Are you already enrolled in a trial? ◯ **Yes** ◯ **No** | Trial#: NCT |
| Clinical trial name: | |
| Clinical trial facility/hospital name: | Is trial currently a primary treatment focus?<br>◯ **Yes** ◯ **No (explain):** |
| Reason for traveling: ☐ Initial Consultation ☐ Study Visits<br>☐ Other **(explain):** | |

## C. Insurance information

Is travel covered by patient's insurance? ◯ **Yes** ◯ **No** ◯ **Limited** (**explain**):_____

| | | |
|---|---|---|
| **Primary insurance name:** | | |
| **Insurance Type**<br>◯ Medicaid-Managed Care ◯ Medicaid-State ◯ Private/Commercial ◯ Tricare<br>◯ Medicare Standard ◯ Medicare-Advantage ◯ No Insurance | | |
| **Policyholder name:** | | |
| **ID#:** | **Plan#:** | **Group#:** |

| | | |
|---|---|---|
| **Secondary insurance name:** | | |
| **Insurance Type**<br>◯ Medicaid-Managed Care ◯ Medicaid-State ◯ Private/Commercial ◯ Tricare<br>◯ Medicare Standard ◯ Medicare-Advantage ◯ No Insurance | | |
| **Policyholder name:** | | |
| **ID#:** | **Plan#:** | **Group#:** |

## E. Household financial information

A household includes everyone who is in the same tax unit- wage earners and dependents - even if they don't live in the same house. How many people are in the patient's household? _____

| **Please attach one of the following to verify income** | | |
|---|---|---|
| ☐ W2 | ☐ Social security statement | ☐ Federal income tax return form |
| ☐ 1 month pay stub | ☐ Other: | |

| Type of income | Monthly income before diagnosis | Monthly income after diagnosis |
|---|---|---|
| Employment | $ | $ |
| Pension | $ | $ |
| Public Assistance | $ | $ |
| Social Security | $ | $ |
| SSI | $ | $ |
| SSDI | $ | $ |
| Unemployment | $ | $ |
| Work Disability | $ | $ |
| Other: | $ | $ |
| **Total:** | $ | $ |

| Monthly costs | |
|---|---|
| Please estimate all household costs, including mortgage/rent, food, utilities, non-trials transportation, insurance, entertainment etc... | $ |
| Please list all additional medical and clinical trials costs, including co-pays, and out-of-pocket costs etc. | $ |
| **Total monthly costs** | $ |

## F. Payment information

**Tip:** If approved for air travel, our travel agents will contact you to book your flight.

**Tip:** If approved for accommodations or ground transportation, a pre-paid MasterCard will be sent to the payee you write below.

**Tip:** *The payee should be someone who can currently handle the household finances and can speak to the bank, if necessary. We recommend you choose someone other than the patient.*

**Tip:** The card will be sent to the exact address you write below. Double check to be sure it's readable and correct. Choose an address where you'll be able to get your mail if you are away from home during the clinical trial process. (Forwarding services don't work for these cards.)

Payee Name:

Payee Date of Birth (mm/dd/yy):

Address to mail card - check here if address is recipient's address, as written in section A: ☐

## G. Travel information

What type of travel grant do you need? Check all that apply:

☐ Patient air travel ☐ Companion air travel ☐ Ground transportation ☐ Accommodations

| **Air Travel** | **Accommodation** |
|---|---|
| - Date of Travel:<br>- Departure Airport code:<br>- Arrival Airport code:<br>- Estimated date of return: | ☐ Hotel/Temporary housing<br>☐ Food<br>☐ Other:_____<br>Length of stay:_____<br>Cost per night: $_____ |

**Ground transportation:**

**-Gas/parking** How many miles a month do you drive to/from clinical trial?

**-Bus/train/cab/etc**. Amount spent traveling to and from clinical trials a month?

## H. Patient/family signature

**I/we certify that all of the information given in this application is true**

| Name Printed: | |
|---|---|
| Signature: | Date: |
| Relationship to Patient: | |
| **Patient/family comments (optional)** | |

## I. Medical representative verification

This rep is who we will contact if we have any questions and who we will email with a grant decision.

| Hospital/clinical trial rep name: | |
|---|---|
| Phone: | Email: |

**Title**

◯ Social Worker ◯ Resource Specialist ◯ Trial Coordinator
◯ Nurse Coordinator ◯ Other:

| Signature: | Date: |
|---|---|

**Medical representative's statement of need.** Address patient's need for grant assistance, as well as eligibility or acceptance into an eligible clinical trial**.** ☐ **Attached**