Patient Financial Assistance

Financial assistance is available thanks to
Be The Match Foundation®

To be eligible for financial assistance, patients must meet all of these requirements:

1. Has a NMDP formal search.

2. Household monthly take home income is within the income caps below:

# of persons in household	All states (except AK & HI), PR and DC	Alaska	Hawaii
1	$5,000	$6,300	$5,800
2	$6,800	$8,600	$7,900
3	$8,700	$10,800	$10,000
4	$10,500	$13,000	$12,000
Each additional person	$1,800	$2,300	$2,000

3. Household income doesn't exceed household costs by more than $200 a month.

4. Medical representative affirms eligibility and submits application by email or fax:
   Email: patientgrants@nmdp.org Fax: 763-406-8169

5. This financial assistance is awarded once per eligible transplant.

Patient Financial Assistance Application

Please make sure to read the requirements on page 1

A. Patient Information

NMDP Recipient ID (optional) _____ Race_____ Ethnicity

First name_____ Last name_____

Date of birth_____ Sex ☐ Male ☐ Female Phone_____

Permanent address_____

city *state* *zip*

Parent/guardian name (peds only) _____

Transplant center (TC) name_____ TC#_____

B. Payment Information

The payment will be sent to the payee information and exact address listed below. We recommend it be someone other than the patient, if possible.

Name of Payee_____

Payee date of birth (mm/dd/yy)_____

How would you like to receive payment *(Choose one)*

☐ Prepaid card *arrives in 4 weeks*

☐ Check *arrives in 1-2 weeks*

☐ Direct deposit *arrives in 3-4 business days**

Please provide information below based off the payment type you chose.
Payment will be sent to the payee name provided.

<u>Prepaid card or check</u>

Address to mail the prepaid card or check ☐ Same as above

Choose an address where you'll be able to get your mail if you are away from home during the transplant process.

_____

city *state* *zip*

<u>Direct deposit</u> –

*A member of our Patient Financial Assistance team will be in touch with you. Additional documentation is needed to process a direct deposit payment.

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C. Insurance Information

Primary insurance company name_____ Issuing state _____

Insurance type

☐ Medicaid – managed care ☐ Medicaid – state ☐ Medicare – Advantage
☐ Medicare – Standard ☐ Private/Commercial ☐ Tricare

Group number _____ Plan number _____ Individual policy number_____

Did the patient have to relocate to be closer to the transplant center? ☐ Yes ☐ No

Total household monthly income (take-home) _____

Total household monthly costs – **for this month only**	
	Usual ongoing costs (mortgage/rent, food, gas, phone, etc.)
	Extra costs needed for transplant (medications, copays, hotels, hospital parking, meals)
	TOTAL – usual costs + extra costs

D. Patient/family verification

Patient/family must sign below to verify that all the information in this application is true.

Signature _____ Date _____

Print name _____ _____
Relationship to the patient

Additional comments from patient/family (optional):

E. Medical representative (rep) verification

Rep name _____ Rep role _____
Email _____ Phone _____
Provide a brief statement of confirm this patient's need for financial assistance (required) ☐ Attached

Your signature below attests to the following two statements:

1. To the best of your knowledge, this information on this form is accurate
2. To the best of your knowledge, this recipient is eligible for financial assistance.

Rep signature _____ Date _____

Email app to patientgrants@nmdp.org or fax to 763-406-8169/phone 763-406-8114

Please visit our Patient Support Center: BeTheMatch.org/patient