Patient Financial Assistance

My patient is enrolled in or in the process of enrolling in a clinical trial

Use the form as guidance for completing the online application. **This is not an application.**

If you have any questions, please contact our Financial Assistance Team at patientgrants@nmdp.org

The patient's household income must be below the 350% federal poverty line.

Poverty Guidelines (Monthly) 48 Contiguous States and D.C.	
Persons in Household	350%
1	$3,721
2	$5,030
3	$6,335
4	$7,641
5	$8,950
6	$10,255
7	$11,561
8	$12,870

Your patient's NMDP Recipient ID (RID) (if applicable):_____

Clinical trial information:

NCT# _____

Name of clinical trial facility/hospital_____

City where clinical trial facility/hospital is located_____

What financial barriers are preventing your patient from moving forward in the clinical trial process? *Select all that apply.*

- ☐ Air travel
- ☐ Caregiver costs
- ☐ Co-pays/co-insurance
- ☐ Ground travel (gas, parking, bus, train, cab, rideshare)
- ☐ Insurance (pending authorization, limited or no coverage)
- ☐ Medication
- ☐ Permanent housing (mortgage/rent, utilities)
- ☐ Required dental work-up or intervention
- ☐ Short-term housing (hotel, AirBnb)
- ☐ Other, please specify: _____

Monthly out-of-pocket treatment costs, not covered by insurance:

Barrier not covered	Monthly costs not covered by insurance ($)
Caregiver costs	
Co-pays/co-insurance	
Required dental work-up or intervention	
Ground travel (gas, parking, bus, train, cab, rideshare)	
Medication	
Permanent housing (mortgage/rent, utilities)	
Short-term housing (hotel, Airbnb)	
Other (please specify)	

List the names of medications or treatments that insurance doesn't cover at all:

As a result of treatment or disease my patient...

	Yes	No
Relocated or will have to relocate		
Experienced a decrease in income		
Has GVHD		

Please affirm your patient's financial need and provide any additional information that we should consider in making a grant decision. Please provide as much detail as possible.

Number of people in patient household (including patient): _____

A household includes everyone who's in the patient's tax unit - wage earners and dependents.

Types of income your patient's household currently receives:

Select all that apply and list amount.

- ☐ Employment $_____
- ☐ Pension $_____
- ☐ Public assistance $_____
- ☐ Social security/retirement $_____
- ☐ Supplemental security income (SSI) $_____
- ☐ Social security disability income (SSDI) $_____
- ☐ Unemployment $_____
- ☐ Work disability $_____
- ☐ Other, please specify: _____
- ☐ My patient's household has no income

Patient's current financial situation:

	Money/assets in checking and savings accounts ($)	Medical and/or credit card debt ($)
Total dollar amount		

Patient's primary insurance:

- ☐ Private/commercial/employer sponsored
- ☐ Medicare–advantage/cost
- ☐ Medicare–standard
- ☐ Medicaid–managed care
- ☐ Medicaid–state/Fee-for-service (FFS)
- ☐ Charity care
- ☐ Tricare
- ☐ Not insured
- ☐ Other, please specify: _____

Is your patient's primary insurance employer-sponsored?

- ☐ Yes, please specify employer: _____
- ☐ No

Patient's primary insurance information:

Write 'N/A' if not applicable.

Insurance company name	
Issuing state	
Insurance policy number	
Insurance plan number	
Insurance group number	

Patient's <u>secondary</u> insurance:

- ☐ My patient does not have secondary insurance
- ☐ Private/commercial/employer sponsored
- ☐ Medicare–advantage/cost
- ☐ Medicare–standard
- ☐ Medicaid–managed care
- ☐ Medicaid–state/Fee-for-services (FFS)
- ☐ Charity care
- ☐ Tricare
- ☐ Other, please specify: _____

Is your patient's <u>secondary</u> insurance employer-sponsored?

- ☐ Yes, please specify employer: _____
- ☐ No

Patient's <u>secondary</u> insurance information:

Write 'N/A' if not applicable.

Insurance company name	
Issuing state	
Insurance policy number	
Insurance plan number	
Insurance group number	
My patient does not my secondary insurance	

Patient information:

First name	
Last name	
Address 1(Street address, P.O. box, company name, c/o)	
Address 2 (Apartment, suite, unit, building, floor, etc.)	
City	
State	
Zip code	
County	
Phone number	
Email address	
Date of birth (mm/dd/yyyy)	

Patient ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer

Patient race: *Select all that apply.*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Prefer not to answer
- ☐ Not listed, please specify:_____

Patient gender:

- ☐ Male
- ☐ Female
- ☐ Prefer not to answer
- ☐ Not listed, please specify: _____

Patient diagnosis:_____

Patient assistance grants are supported through philanthropy and sharing patient stories helps to inspire the financial support that sustains this program. Your decision will not impact the patient's relationship with Be The Match or the amount of financial assistance awarded.

My patient gives consent to...

	Yes	No
Share their story anonymously to Be The Match/NMDP employees and partners		
Have a member of the Be The Match/NMDP team contact them to talk about sharing their story		

Payment Information

Payee name (person the money will be going to):

First name	
Last name	
Date of birth (mm/dd/yyyy)	

Payment preference:

- ☐ Prepaid Visa card (arrives in 4 weeks)
- ☐ Check (arrives in 1-2 weeks)
- ☐ Direct deposit* (arrives in 3-4 business days)

The payment will be sent to the payee information and exact address provided below. Choose an address where you will be able to get your mail if you are away from home during the treatment process.

Address to mail prepaid card or check:

Address 1(Street address, P.O. box, company name, c/o)	
Address 2 (Apartment, suite, unit, building, floor, etc.)	
City	
State	
Zip code	

***Additional documentation will need to be completed.**

Please click the link below and work with the payee to complete the required ACH form for direct deposit. The payee MUST sign the form. Electronic signature will be accepted.

Once complete, return form to patientgrants@nmdp.org ACH Payment Enrollment Form