# Patient Financial Assistance

***The patient is pre-transplant and has a formal search through the NMDP/Be The Match Registry with the intention to move forward with an allogeneic transplant that is facilitated by NMDP/Be The Match (related or unrelated)***

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

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

The patient's **monthly** household income must not exceed the 350% federal poverty line.

| Poverty Guidelines<br>*Patient's monthly take home household income must not exceed 350% of the federal poverty line* | | | |
|---|---|---|---|
| **Persons in Household** | **Monthly (Take Home) Household Income *48 Contiguous States and D.C.*** | **Monthly (Take Home) Household Income *Alaska*** | **Monthly (Take Home) Household Income *Hawaii*** |
| 1 | $3,757 | $4,693 | $4,323 |
| 2 | $5,081 | $6,350 | $5,845 |
| 3 | $6,405 | $8,006 | $7,368 |
| 4 | $7,729 | $9,663 | $8,890 |
| 5 | $9,053 | $11,320 | $10,413 |
| 6 | $10,378 | $12,976 | $11,935 |
| 7 | $11,702 | $14,633 | $13,458 |
| 8 | $13,026 | $16,290 | $14,980 |

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

**What financial barrier(s) is preventing your patient from moving forward in the treatment process?** *Select all that apply.*

- ☐ Air travel
- ☐ Caregiver costs
- ☐ Ground travel (gas, parking, bus, train, cab, rideshare)
- ☐ Insurance (co-pays/co-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 <u>treatment costs</u>, not covered by insurance:**

| Barrier not covered | Monthly costs not covered by insurance ($) |
|---|---|
| Air travel | |
| Caregiver costs | |
| Ground travel (gas, parking, bus, train, cab, rideshare) | |
| Insurance (pending authorization, limited or no coverage, co-pays/co-insurance) | |
| Medication | |
| Permanent housing (mortgage/rent, utilities) | |
| Required dental work-up or intervention | |
| Short-term housing (hotel, Airbnb) | |
| Other (please specify) | |

**Number of people in patient's household (including patient):** _____

*A household includes everyone who's in the patient's tax unit - wage earners and dependents. (i.e. who does the patient files taxes with?)*

**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 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: _____

**Patient's primary insurance information:**

Write 'N/A' if not applicable.

| | |
|---|---|
| Insurance company name | |
| Issuing state | |

**Patient's secondary insurance:**

- ☐ My patient does not have secondary 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: _____

**Patient's secondary insurance information:**

Write 'N/A' if not applicable.

| | |
|---|---|
| Insurance company name | |
| Issuing state | |
| My patient does not my secondary insurance | |

**Patient information:**

| | |
|---|---|
| First name | |
| Last name | |
| Guardian name (peds only) | |
| Address 1(Street address, P.O. box, company name, c/o) | |
| Address 2 (Apartment, suite, unit, building, floor, etc.) | |
| City | |
| State | |
| Zip code | |
| 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 NMDP/Be The Match or the amount of financial assistance awarded.**

My patient gives consent to...

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

## Payment Information

**Payee name (person who will receive the money):**

| | |
|---|---|
| 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:**

Is the address provided earlier in the application the same as the payee address?
If yes, please leave the table below blank. If no, please provide the correct address below.

| | |
|---|---|
| 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's name MUST match the name on the bank account provided, or the funds will be returned. The payee MUST sign the ACH form. Electronic signature will be accepted.patientgrants@nmdp.org ACH Payment Enrollment Form

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