Patient Financial Assistance

My patient is enrolled or in the process of enrolling in a clinical trial for a blood cancer or disorder and needs assistance covering travel expenses

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 (Monthly) 48 Contiguous States and D.C.	
Persons in Household	350%
1	$3,722
2	$5,028
3	$6,335
4	$7,642
5	$8,948
6	$10,255
7	$11,562
8	$12,868

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

Clinical trial information:

National Clinical Trial (NCT) indicator number _____
Name of clinical trial facility/hospital _____
City where clinical trial facility/hospital is located _____

What financial barrier(s) is your patient facing in the clinical trial process?

Select all that apply.

- ☐ Air travel
- ☐ Accommodations (hotel/temporary housing, food)
- ☐ Ground transportation/parking

Cost of barrier(s) associated with clinical trial:

Barrier from list above	Cost ($)
Air travel	
Accommodations	Hotel/temporary housing: • Number of nights: _____ • Cost per night: _____ Food: _____ Other accommodation costs: _____
Ground transportation/parking	Number of miles traveled to/from clinical trial: _____ Number of times traveled to clinical trial: _____ Other ground transportation/parking costs: _____

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 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 payment):

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 any additional information that we should consider in making a grant decision. Please provide as much detail as possible.