Patient Financial Assistance

The patient had an NMDP/Be The Match facilitated related or unrelated donor transplant, is at least 90 days post-transplant and actively being treated for chronic GVHD

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 *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): _____

	Month	**Day**	**Year**
Patient transplant date			

As a result of transplant my patient...

Has chronic GVHD	Yes ☐	No ☐

If yes, how frequently is your patient being seen for chronic GVHD?

- ☐ More than once per month
- ☐ Once per month
- ☐ Less than once per month
- ☐ Other, please specify _____

If yes, is your patient taking medication to treat chronic GHVD?

- ☐ Yes
- ☐ No

What financial barrier(s) is your patient facing due to chronic GVHD treatment?
Select all that apply.

- ☐ Ground travel to/from appointments (gas, parking, bus, train, cab, rideshare)
- ☐ Insurance (co-pays/co-insurance, pending authorization, limited or no coverage)
- ☐ Medication
- ☐ Other, please specify:

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

Barrier not covered	Monthly costs not covered by insurance ($)
Ground travel to/from appointments (gas, parking, bus, train, cab, rideshare)	
Insurance (co-pays/co-insurance, pending authorization, limited or no coverage)	
Medication	
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 <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-service (FFS)
- ☐ Charity care
- ☐ Tricare
- ☐ Not insured
- ☐ Other, please specify: _____

Patient's <u>secondary</u> 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 a statement of need any additional information that we should consider in making a grant decision. Please provide as much detail as possible.