RESET PRINT

Financial Grants Worksheet

Note: This is not the actual application

The answers in this worksheet can help you or your child's transplant team apply for financial grants for you. Please complete this worksheet as detailed as you can. Your answers help us match the best grant(s) for you.

Directions: Please fill out the entire Section 1. Then, review the scenarios in Section 2. Please fill out any that apply to you. Once complete, send this to your BMT Social Worker or the Be The Match Patient Support Center (email below).

If you have questions, our Patient Navigators can help.

- Call 1 (888) 999-6743
- Email patientinfo@nmdp.org

Section 1: General Information

A. About you (patient)

Recipient ID (RID), if known	
Patient name (first and last)	
Date of birth (mm/dd/yyyy)	
Guardian name (if patient is a child)	
Diagnosis	
If you've already had transplant, what was your transplant date? (mm/dd/yyyy)	
Phone number	
Email address	

Address	
Home Address (Street Address, P.O. Box, Company Name, C/O)	
Home Address Line 2 (if applicable) (Apartment, Suite, Unit, Building, Floor, etc.)	
City, State	
Zip Code	

Are you staying somewhere else while getting treatment? **If yes, write your temporary address below.**	◯ Yes	◯ No
Temporary Address (Street Address, P.O. Box, Company Name, C/O)		
Temporary Address Line 2 (if applicable) (Apartment, Suite, Unit, Building, Floor, etc.)		
City, State		
Zip code		

Note: We ask for information like gender and race to make sure we're reaching a variety of people. This information does **not** impact our decision to give you a grant. Group data may be shared internally, but your name and individual answers will not be shared.

What is your gender identity?

We invite you to share how you identify. You do **not** have to answer if you don't want to. Gender identity is your personal sense of self and gender, whether that be man, woman, neither, both or somewhere in-between.

What is your race? Select all that apply.

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

What is your ethnicity?

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

B. Insurance

☐ I am not insured. If you checked this box, skip to **Section C.**

If you have insurance:	
Insurance company name	
Issuing state (State you receive your insurance from)	
If you have a second insurance:	
Insurance company name	
Issuing state (State you receive your insurance from)	

C. Transplant Out-of-Pocket Costs

Item	**Amount you pay each month (not covered by your insurance)**
Air Travel	
Caregiver Costs (Travel, Food, Loss of Wages, etc.)	
Ground Travel (Gas, Parking, Bus, Train, Rideshare)	
Medical Costs (Insurance, Medications, Required Dental Work, etc.)	
Permanent Housing (Mortgage, Rent, Utilities)	
Temporary Housing (Hotel, Airbnb, etc.)	
Other, please specify:	

What are you having trouble paying for? Select all that apply.

- ☐ Air Travel
- ☐ Caregiver Costs (Travel, Food, Loss of Wages, etc.)
- ☐ Ground Travel (Gas, Parking, Bus, Train, Rideshare)
- ☐ Medical Costs (Insurance, Medications, Required Dental Work, etc.)
- ☐ Permanent Housing (Mortgage, Rent, Utilities)
- ☐ Temporary Housing (Hotel, Airbnb, etc.)
- ☐ Other, please specify: _____

D. Household income

Your household is everyone living in your home, who is 18 and older or listed as a dependent on your taxes. It does **not** include:

- Roommates
- A legally separated or divorced spouse

Using the definition above, how many people live in your household (including you)?

_____

☐ My household has no income. If you checked this box, skip to **Section E.**

Item	Household income each month
After-tax wages, tips and bonuses	
Retirement plan(s) (pensions)	
Public assistance	
Social Security	
Supplemental Security Income (SSI)	
Social Security Disability Income (SSDI)	
Unemployment	
Work disability	
Other, please specify:	

E. Payment

Payee full name (person who will receive the payment):

_____

Payee 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)

*If you choose direct deposit, you'll also need to complete a separate ACH form. If you have questions, our Patient Navigators can help. Call 1 (888) 999-6743 or email patientinfo@nmdp.org.

If you selected prepaid Visa or Check above, please tell us where to mail it:	
◯ Please use the **home address** listed in **Section A** ◯ Please use the **temporary address** listed in **Section A** ◯ Please use the address below	
Address (Street Address, P.O. Box, Company Name, C/O)	
Address Line 2 (Apartment, Suite, Unit, Building, Floor, etc.)	
City, State	
Zip Code	

F. Describe your situation

Please describe your situation and why you need help from a grant. Give any additional information we should know in making a grant decision. Please give as much detail as possible.

G. (Optional) Sharing your story

Our grants are supported through philanthropy. With your permission, your story can help us inspire the financial support that keeps this program running. Your answers will **not** affect your relationship with Be The Match or how much money you're given.

I would like to…	Yes	No
Share my story above anonymously with Be The Match employees and funders	○	○
Have someone from Be The Match contact me to talk about sharing my story	○	○

Section 2: Additional Information

Which scenario applies to you (if any)? Select all that apply.	**Yes**	**No**
I received a transplant through Be The Match more than 3 months ago and I'm getting treatment for chronic GVHD. If you checked yes, fill out **Section A** below.	○	○
I am enrolled or in the process of enrolling in a clinical trial (for a blood cancer or disorder) and I need help with travel expenses. If you checked yes, fill out **Section B** below.	○	○

A. Chronic GVHD treatment

Are you taking medicines to treat chronic GVHD?

- ○ Yes
- ○ No

How often do you go to the doctor for chronic GVHD?

- ○ More than once a month
- ○ Once a month
- ○ Less than once a month
- ○ Other, please specify: _____

B. Clinical trials

National Clinical Trial (NCT) number	
Name of clinical trial facility/hospital	
Where is the clinical trial facility/hospital located? (City, State)	
How long will you be getting treatment in the clinical trial? (6 Months, 1 Year, 2 Years, etc.)	

Clinical trial travel costs	
How many times do you need to go in to the clinical trial facility/hospital **each month?**	
How many nights do you need to stay in temporary housing for **each visit?** (temporary housing would be a hotel, Airbnb, etc.)	
How much does it cost each night?	
How much do you spend on food for **each visit?**	
If you use your own car to travel:	
How many miles do you travel to and from **each visit?**	
How much do you spend on parking for **each visit?**	
If you **don't** use your own car to travel:	
How much do you spend on transportation for **each visit?**	