FINANCIAL ASSISTANCE APPLICATION

The Davidson Leukemia Foundation

CLIENT INFORMATION

First Name | Middle Name | Last Name

Mailing Address | Apartment/Unit#

City | State | Zip Code | County

Home Phone | Cell Phone | E-mail

Male ☐ Female ☐ | Marital Status | Spouse's Name (if applicable)

__/__/__ | Date of Birth | Age | Social Security Number

Total # of People Living in Household | # Adults in Household | # Children in Household

__/__/__ | Date of Transplant (if applicable) | Hospital/Clinic

DEMOGRAPHIC INFORMATION

Race (optional - please check) ☐ Hispanic ☐ African American ☐ Black ☐ White, Non-Hispanic ☐ Asian-American ☐ Asian-Pacific Islander ☐ Native American ☐ Other _____

Level of Education (optional - please check) ☐ GED ☐ Attended High School (# of years ____) ☐ High School Graduate ☐ Technical Certificate/Diploma ☐ Currently Enrolled in College ☐ Attended College (# of years _____) ☐ Associates Degree ☐ Bachelors Degree ☐ Post-Graduate Degree ☐ Other _____

Work Status (please check) ☐ Currently Employed; Employer Name _____ ☐ Medically Disabled _____ Date ☐ Retired ☐ Unemployed _____ Date

Current Source of Income (please check all that apply) ☐ Full-Time Employment ☐ with benefits ☐ Working Spouse ☐Part-Time Employment ☐ with benefits ☐ Parent(s) Income ☐ Retirement Pension ☐ Social Security Retirement ☐ Social Security Disability (SSDI) ☐ Supplemental Security Income (SSI)

Current Source of Healthcare Coverage (please check all that apply) ☐ Insurance (please circle: BCBS; United Healthcare; Humana; Kaiser; Aetna; Other _____) ☐ Spouse's Insurance ☐ Medicare ☐ Medicaid ☐ QMB Medicaid ☐ Spend-down Medicaid ☐ COBRA

Check all that apply to you: ☐ BMT Recipient ☐ Bone Marrow Donor ☐ Autologous ☐ Allogeneic ☐ TDLF Volunteer/ Board Member/ Committee Member ☐ Mentor/Mentee

How did you hear about TDLF services? ☐ TDLF Website/ Brochure ☐ TDLF Staff, Name: ☐ TDLF Volunteer, Name: ☐ Hospital/Clinic Staff, Name :

Patient's Name_____

*PLEASE ANSWER **ALL** QUESTIONS FOR THE REVIEW COMMITTEE*

PART THREE - FINANCIAL INFORMATION

DO NOT LEAVE ANY FIELD BLANK

ASSETS:

CHECKING	$
SAVINGS	$
STOCKS & BONDS	$
RETIREMENT ACCOUNTS	$

AUTOMOBILE(S):

YEAR _____ YEAR _____

MAKE _____ MAKE _____

Household: All people living in your home (includes all children, adults, or minors), non-related household members, parents, grandchildren, siblings, renters, etc.
Income: Total amount for wages or salary income, self-employment income, interests, dividends and rental income, Social Security Retirement and Social Security Disability income, Supplemental Security Income, child support, public assistance, TANF, food stamps, family's financial help, income from working children, parents, siblings, etc. who reside in your household.
Expenses: General household expenses per month - rent/mortgage, food, average utilities, phone charges - basic phone, cell phone, credit card payments - monthly amount, not total balances owed.

MONTHLY HOUSEHOLD NET INCOME

(please read above description)

WAGES (net)	$
SPOUSE'S INCOME	$
FAMILY MEMBER'S INCOME	$
SOCIAL SECURITY (SSDI, SSI)	$
ADDITIONAL DISABILITY	$
PENSION	$
RETIREMENT INCOME	$
VETERAN'S PENSION	$
TANF	$
FOOD STAMPS	$
RENTAL INCOME	$
DIVIDENDS	
OTHER	$
_____	$
TOTAL MONTHLY INCOME	**$**

I authorize information released between TDLF and my Hospital/Clinic or other related parties to verify information related to this request. I agree to be added to TDLF's database for future mailings.

_____

APPLICANT'S SIGNATURE **DATE**

MONTHLY HOUSEHOLD EXPENSES

(please read above description)

RENT* ☐ MORTGAGE* ☐	$
FOOD	$
UTILITIES	
TELEPHONE	$
GAS & ELECTRICITY	$
CELL PHONE	$
WATER	$
TRANSPORTATION	
PUBLIC TRANSPORTATION	$
AUTO PAYMENT	$
GASOLINE	$
MEDICAL EXPENSES	
DOCTORS FEES	$
HOSPITAL PAYMENTS	$
MEDICATIONS	$
DENTAL	$
INSURANCE	
MEDICAL	$
LIFE	$
AUTO	$
CHARGE ACCOUNTS	
BANK CARDS (monthly payment)	$
OTHER _____	$
OTHER _____	$
TOTAL MONTHLY EXPENSES**	**$**

*** If you are not paying rent or a mortgage, please explain:** _____

**** If your monthly expenses are more than your monthly income, please explain how you are paying your bills each month:**

Patient's Name_____

Check(s) Payable to: (List name of payee and attach supporting documents)

1. _____ AMT $ _____

2. _____ AMT $ _____

3. _____ AMT $ _____

TOTAL AMOUNT REQUESTED: $ _____

Social Worker's/Coordinator's Statement:

(Pease document fully the background information creating the need and your recommendations)

Requesting Social Worker/Coordinator _____ **Date** _____

Center Name _____ **Phone** _____ **Pager** _____

- **Checks will be made payable to the companies stated above and mailed to the applicant, unless stated otherwise.**
- **Please remember to complete the appropriate authorization forms, if needed for your request and include supporting documentation.**
- **Please verify that the address and financial information is current and complete.**

Revised July 2015