**The Leukemia & Lymphoma Society’s Travel Assistance Program (FY19)**

**What is the Travel Assistance Program?**
The Leukemia & Lymphoma Society, Minnesota Chapter’s Travel Assistance Program is available for qualified blood cancer patients with financial need. A grant will help a patient and family travel to health care providers for their blood cancer related treatments. Approved travel expenses include ground transportation (gas, tolls, car rental, taxi, bus, train, etc.), air travel (baggage fees excluded), ambulance services, and lodging related expenses. **An annual one-time grant of $500.00 per patient is available for qualified individuals between July 1, 2018 and June 30, 2019.**

**Program Criteria:**
1. Be a US citizen or permanent resident.
2. Have a confirmed diagnosis of blood cancer.
3. Be at or below an annual income level of 500% of Federal Poverty Guidelines (see below).
4. Patient must be a resident of Minnesota, North Dakota or South Dakota to qualify.

Return the completed application to the LLS Minnesota Chapter, also serving North Dakota & South Dakota.

** Assistance is based on available funding and the program may be discontinued at any time, without notice.

**2018 Health & Human Services Poverty Guidelines & Dollar Figures for 500% above the Federal Poverty Guidelines**

<table>
<thead>
<tr>
<th>Persons in Family or Household</th>
<th>If you live in 48 Contiguous States, Puerto Rico and D.C. Your household income must be at or below</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$60,700</td>
</tr>
<tr>
<td>2</td>
<td>$82,300</td>
</tr>
<tr>
<td>3</td>
<td>$103,900</td>
</tr>
<tr>
<td>4</td>
<td>$125,500</td>
</tr>
<tr>
<td>5</td>
<td>$147,100</td>
</tr>
<tr>
<td>6</td>
<td>$168,700</td>
</tr>
<tr>
<td>7</td>
<td>$190,300</td>
</tr>
<tr>
<td>8</td>
<td>$211,900</td>
</tr>
</tbody>
</table>

For each additional person add $4,320

The above Federal Poverty Guidelines adapted scale is to be used as a reference tool only, it does not guarantee acceptance into the program.

Your income can also be impacted by the Cost of Living Index (COLI) in your area. To be eligible for the Travel Assistance Program, your household income must be at or below 500% of the Federal Poverty Level as adjusted by the Cost of Living Index (COLI).

**SOURCE:** Federal Register, January 18, 2018

https://aspe.hhs.gov/poverty-guidelines

Adapted by The Leukemia & Lymphoma Society’s Travel Assistance Program
The Leukemia & Lymphoma Society’s Travel Assistance Program
- FY19 Application Form -

The application must be completed in its entirety, and must be signed by both the designee and the patient in the areas specified on the form below.

### Patient Information

<table>
<thead>
<tr>
<th>Patient First &amp; Last Name: _______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>(** If patient is less than 18 years of age, please also provide legal parent/guardian first &amp; last name below **)</td>
</tr>
<tr>
<td>Parent/Guardian Full Name: _______________________________ Relationship to patient: ______________</td>
</tr>
<tr>
<td>Home Address: ___________________________________________ Apt. # __________</td>
</tr>
<tr>
<td>City/State/Zip Code: ___________________________________________</td>
</tr>
<tr>
<td>Email: _______________________________ Home/ Cell Phone: ( ) ______________</td>
</tr>
</tbody>
</table>

How did you hear about the Travel Assistance Program?

- [ ] Doctor
- [ ] Nurse
- [ ] Social Worker
- [ ] Friend/Family Member
- [ ] Other (please specify): ___________________________________________

<table>
<thead>
<tr>
<th>Patient’s Gender: [ ] Male [ ] Female</th>
</tr>
</thead>
</table>

PATIENT’S DATE OF BIRTH: _____/_____/_______

Are you of Hispanic or Latino origin or descent?  
- [ ] Hispanic or Latino
- [ ] Not Hispanic or Latino

Which of the following best describes your race?  
- [ ] White or Caucasian
- [ ] Black or African-American
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] American Indian or Alaska Native
- [ ] Other: ____________________________

### Medical Information

To be completed by the patient’s prescribing healthcare provider or designee. Please note, stamps or initials will not be accepted. A designee is defined as a nurse, social worker or physician.

<table>
<thead>
<tr>
<th>Patient Diagnosis/Subtype: _______________________________</th>
</tr>
</thead>
</table>

Date of Diagnosis: ___________________________

<table>
<thead>
<tr>
<th>Is patient in active treatment and/or ongoing follow-up? [ ] Yes [ ] No</th>
</tr>
</thead>
</table>

Physician’s Name: ___________________________________________ Hospital/Clinic: ___________________________

| Designee (signer’s) Name/Title: ___________________________
| --- |

Address: ___________________________________________ City/State/Zip: ___________________________

| Phone: ( ) ___________________________ Healthcare Provider License #: ___________________________
| --- |

Healthcare Provider Signature: ___________________________ Date: _____/_____/_______
The Leukemia & Lymphoma Society’s Travel Assistance Program
- FY19 Application Continued -

Health Insurance Information

Do you currently have health insurance? □ Yes □ No. If yes, please check which one:

Medicare Part B: □ Medicare Part D: □ Medicaid: □ Health Exchange Plan: □ Commercial: □
Other □ (if other, please specify)

Are you currently receiving assistance from the LLS Co-Pay Assistance Program? □ Yes □ No

Household Financial Information

Number of people in the household: ____________ Is the patient/guardian currently employed? □ Yes □ No

Current ANNUAL household income: ________________________________

Patient Signature & Attestation

PLEASE NOTE: By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate, and if asked, I agree that I can, and will, provide documentation showing that the household’s annual income is equal to or less than 500% of the Federal Poverty Level, examples of which have been provided to me with this application form.

I further attest that if approved for a travel grant, the funds will be used for treatment-related travel.

Patient/Guardian Signature: ______________________________________ Date: ____/____/_____

Patient/Guardian Print Name: ___________________________________________________

PLEASE RETURN FORM TO THE LEUKEMIA & LYMPHOMA SOCIETY
MINNESOTA CHAPTER ALSO SERVING NORTH DAKOTA & SOUTH DAKOTA
1711 Broadway Street NE, Minneapolis MN 55413
PHONE: 612-259-4600 | FAX: 612-259-4601

This local travel assistance program is

Made possible by the Douglas J. Olson Memorial Fund for Patients
generously supported by the Earl D. and Marian N. Olson Fund of The Saint Paul Foundation
and falls under the umbrella of The Leukemia & Lymphoma Society’s
Susan Lang Pay-it-Forward Patient Travel Assistance Program