Leukemia Research Foundation

Patient Grant Program Application

Program eligibility and requirements

The Leukemia Research Foundation Patient Grant is a one-time grant of up to $1,500 available to eligible patients with a leukemia diagnosis. If the patient is under 18 years of age, a parent or guardian must submit the required information.

Eligibility

- Applicant must reside within the state of Illinois or within 100 miles of Chicago.
- Applicant household income can be no more than 400 percent of the Federal government's poverty level. The most current Federal poverty guidelines will be used to determine income level per size of household. Poverty guidelines can be found on page six.
- Applicant must have a leukemia diagnosis and must be in active treatment as certified by a physician (or nurse practitioner).

Required documents

1. **Diagnosis and treatment confirmation**: Letter from treating physician (or nurse practitioner) confirming leukemia diagnosis and verifying patient is in active treatment. The letter should be dated no earlier than January 2022.
2. **Income documentation:** Copy of applicant household federal tax return for the most recent year (only the page showing income is required). If applicant does not file a tax return, a copy of a benefits statement (such as disability or unemployment) or a copy of a most recent pay stub (for all household members) may be submitted.

We may also request (not required at time application, but may be requested during application review):

- Applicant's household bank statements from the last three months, including checking, savings, CDs, and money markets.
- Verification of employment.
- Copy of applicant's driver's license or state ID.
- Interview with applicant or family member to clarify information in the application.

Submission instructions

The preferred submission method to expedite the process is to submit an online application at leukemiarf.org/patients/grants. If you are unable to complete the online application, you may either email your application to carrie@leukemiarf.org or send it via mail to:

Leukemia Research Foundation
Attn: Patient Grant Program
191 Waukegan Road, Suite 105
Northfield, IL 60093

Applicant information

Contact information

Patient last name: _____ Patient first name: _____

Birthdate: ____/____/____ Today's date: ____/____/____ Gender: Male Female

Parent/guardian (if patient under 18): _____ Relationship to patient: _____

Home address: _____ City, state, zip: _____

Home phone: _____ Cell phone: _____

Email address: _____

Number of people living in household: ____

Marital status: Married Not Married Spouse/partner name (if applicable): _____

Do you have any dependents? Yes No If yes, please list name, date of birth, and relationship:

_____

Personal information

Type of leukemia (select one): AML CML ALL CLL

Specific diagnosis: _____ Month/year of diagnosis: ____/_____

Primary medical insurance: _____

Treating hospital or medical center: _____ Address: _____

Treating physician: _____ Physician phone: _____

Social worker: _____ Social worker phone: _____

Social worker email: _____

How did you hear about the Patient Grant Program?

Leukemia Research Foundation website Other website Medical institution/social worker

Friend/family Email Other (please specify): _____

Applicant information (continued)

Race/ethnicity (OPTIONAL)

Please note that answering this question does *not* affect your grant eligibility and the purpose is solely to gather statistical information.

White	Hispanic or Latino	American Indian or Alaska Native
Asian	Black or African-American	Native Hawaiian or Other Pacific Islander

Other (please specify): _____

Patient employment (parent or legal guardian, if applicable)

Employment status: Employed Unemployed Retired Disabled

Employer's name: _____

Annual gross income: _____

Spouse/partner employment (if applicable)

Employment status: Employed Unemployed Retired Disabled

Employer's name: _____

Annual gross income: _____

Request for assistance

Following are examples of the types of assistance provided by the Leukemia Research Foundation: rent/mortgage, transportation/parking, lodging, caregiving, meals/groceries, utilities, child care, medical bills/co-pays, medical equipment, pharmacy/medications.

Total grant amount requested **(maximum request of $1,500):** _____

Please select the type(s) of assistance you are requesting (check all that apply):

Rent/mortgage	Transportation/parking	Lodging	Caregiving
Meals/groceries	Medical bills/co-pays	Child care	Utilities
Medical equipment	Pharmacy/medications	Other (please specify): _____	

Please provide a brief explanation detailing your request for assistance.

Required document checklist

Please note that your application **will not be accepted** without the below documents.

- ☐ **Diagnosis and treatment confirmation letter**
  Letter from treating physician (or nurse practitioner) confirming leukemia diagnosis and verifying patient is in active treatment. The letter should be dated no earlier than January 2022.

- ☐ **Income documentation**
  Copy of applicant household federal tax return for the most recent year (page showing income). If applicant does not file a tax return, a copy of a benefits statement (such as disability or unemployment) or a copy of a most recent pay stub (for all household members) may be submitted.

Patient Grant terms

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I hereby agree as follows:

I hereby authorize the release of information necessary for this application to the Leukemia Research Foundation ("the Foundation"), so that the Foundation can process my request for assistance. I certify the information I have stated here is true and correct and that I am eligible for this Grant based on the Foundation's requirements stated above. I also understand that the Foundation may verify the information on this application and that deliberate misrepresentation of information may subject me to denial of assistance and/or services. I give permission to the Foundation to discuss this application with others deemed necessary to verify my information/identify additional sources of assistance. I understand that all information will remain as private as possible within these entities.

The Foundation reserves the right to determine if I meet the criteria based on an internal review of the application and other supportive materials, and is not required to provide a reason for denied applications.

In addition to the above Grant requirements, in the event I am awarded this Grant, I may be requested to submit to a photo for the Foundation's use. Should that request occur and I approve its use, I hereby irrevocably grant the Foundation and its licensees, assigns, successors, and other parties acting with its permission the perpetual rights to use my name (first name, first initial of last name), image, and personal story (including without limitation how this Grant will be used) in the Foundation's informational and promotional materials.

Nothing in this agreement shall obligate the Foundation or any third party to make any use of the rights granted by me under these Terms. I hereby waive any right to inspect or approve any party's use or exploitation of the rights granted under this agreement.

I hereby release and discharge the Foundation and its licensees, assigns, successors and other parties acting with its permission from any and all claims and demands arising out of or in connection with the exploitation of the rights granted under these Terms, including, without limitation, any and all claims for compensation, claims of defamation or any claims regarding rights of privacy or publicity.

To protect my identity, I understand the Foundation will only use my first name and the first initial of my last name in promotional materials. The Foundation will not use my full last name on any promotional materials. I also agree to allow the Foundation to include my contact information (provided on this application) in their private foundation database, which is primarily used to mail important foundation and leukemia information to donors and friends of the Foundation.

I hereby warrant that I am at least age eighteen (18), or a dependent, have the legal capacity to enter into this agreement, and am not restricted from entering into this agreement. I state further that I have read these Terms in their entirety prior to affixing my signature below, and that I am fully familiar with the contents of these Terms and that I will comply fully with them. These Terms shall be binding upon me and my heirs, legal representatives, and assigns. The invalidity or unenforceability of any provision of these Terms shall not affect the validity or enforceability of any other provision of these Terms.

Patient signature: _____ Printed name: _____ Date: _____/_____/_____

Parent/guardian signature (if patient under 18): _____

Printed name: _____ Date: _____/_____/_____

Poverty guidelines

» All states except Alaska and Hawaii.
» For families/households with more than eight persons, add $4,720 for each additional person to the poverty guideline.

Family/household size	Poverty guideline	400% of federal poverty line
1	$14,580	$58,320
2	$19,720	$78,880
3	$24,860	$99,440
4	$30,000	$120,000
5	$35,140	$140,560
6	$40,280	$161,120
7	$45,420	$181,680
8	$50,560	$202,240