



Please complete the form and mail to:

Children's Leukemia Research Association, Inc.  
Patient Aid Department  
585 Stewart Avenue, Suite 18  
Garden City, NY 11530

## Patient Aid Application

### Patient Information

First Name : \_\_\_\_\_ MI : \_\_\_\_ Last Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_) \_\_\_\_\_ Email : \_\_\_\_\_

Social Security # : \_\_\_\_\_ Date of Birth (mm/dd/yyyy) : \_\_\_\_\_  Male  Female

School or Employer : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Business Telephone : \_(\_\_\_\_\_) \_\_\_\_\_

Name of employee benefits administrator at place of employment : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_) \_\_\_\_\_

Is patient aware of his/her condition?  Yes  No

**Complete if Patient is a Child or Dependent**

**Mother/Guardian**

First Name : \_\_\_\_\_ MI : \_\_\_\_ Last Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_ Email : \_\_\_\_\_

Social Security # : \_\_\_\_\_

**(Signature required)** \_\_\_\_\_ Date : \_\_\_\_\_

Occupation : \_\_\_\_\_ Employer : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Business Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_

Name of employee benefits administrator at place of employment : \_\_\_\_\_

Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_

**Father/Guardian**

First Name : \_\_\_\_\_ MI : \_\_\_\_ Last Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_ Email : \_\_\_\_\_

Social Security # : \_\_\_\_\_

**(Signature required)** \_\_\_\_\_ Date : \_\_\_\_\_

Occupation : \_\_\_\_\_ Employer : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Business Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_

Name of employee benefits administrator at place of employment : \_\_\_\_\_

Telephone : \_( \_\_\_\_\_ ) \_\_\_\_\_

**List Family Members and Ages of All Children**

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

Name : \_\_\_\_\_ Age : \_\_\_\_\_

**Brief Medical History of Patient** (to be completed by attending physician)

**USE CONTINUATION SHEETS WHERE NECESSARY**

Date of Diagnosis : \_\_\_\_\_

Diagnosis : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's First Name : \_\_\_\_\_ MI : \_\_\_\_ Last Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_) \_\_\_\_\_ Email : \_\_\_\_\_

Social Security # : \_\_\_\_\_

License # : \_\_\_\_\_

DEA # : \_\_\_\_\_

**Attending Physician's Signature**

(Signature required) \_\_\_\_\_ Date : \_\_\_\_\_

## Medical Insurance Plan

Policy Holder

First Name : \_\_\_\_\_ MI : \_\_\_\_ Last Name : \_\_\_\_\_

Insurance Company Name : \_\_\_\_\_

Address : \_\_\_\_\_

City : \_\_\_\_\_ State : \_\_\_\_\_ Zip Code : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_) \_\_\_\_\_ Policy # : \_\_\_\_\_

Insurance Company Representative : \_\_\_\_\_ Telephone : \_(\_\_\_\_\_) \_\_\_\_\_

Amount of Deductible : Family \$ \_\_\_\_\_ Individual \$ \_\_\_\_\_

Co-Insurance (% split e.g., 80-20, 60-40) : \_\_\_\_\_

## Other Supplement Insurance (non-governmental)

### Medicare/Medicaid

Is patient enrolled in MEDICARE?  Yes  No MEDICARE claim # : \_\_\_\_\_

Is patient enrolled in MEDICAID?  Yes  No MEDICAID claim # : \_\_\_\_\_

Is a MEDICAID card used to help with prescriptions?  Yes  No

Co-Insurance (% split e.g., 80-20, 60-40) : \_\_\_\_\_

Do you belong to a drug prescription plan?  Yes  No

**If yes, complete the following:**

Insurance Company Representative : \_\_\_\_\_ Telephone : \_(\_\_\_\_\_) \_\_\_\_\_

Member ID # : \_\_\_\_\_

Is the patient a veteran of the United States Armed Forces?  Yes  No

Other Assisting Agencies (e.g., American Cancer Society, etc) : \_\_\_\_\_

Social Worker Name : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_) \_\_\_\_\_

Affiliation : \_\_\_\_\_

Who referred you to Children's Leukemia Research Association? \_\_\_\_\_

I HEREBY AFFIRM, UNDER THE PENALTIES OF PERJURY, THAT I DO NOT HAVE AVAILABLE INSURANCE COVERAGE, THE REQUISITE MEANS, OR ANY OTHER SOURCE OF REIMBURSEMENT FOR THE AMOUNT FOR WHICH I SEEK ASSISTANCE. I ALSO CERTIFY THAT ALL THE INFORMATION PROVIDED ON THIS APPLICATION IS TRUE, AND THAT THE PATIENT AID COMMITTEE OF THE NATIONAL LEUKEMIA RESEARCH ASSOCIATION HAS THE RIGHT TO TERMINATE ANY OR ALL ASSISTANCE TO THE PATIENT UPON PERIODIC REVIEW OF THE CASE, IF NECESSARY.

**Patient or Responsible Adult's Signature**

(Signature required) \_\_\_\_\_ Date : \_\_\_\_\_

Address : \_\_\_\_\_

Telephone : \_(\_\_\_\_\_)\_\_\_\_\_