

Patient Assistance Fund - Request Form

Language

English

The BMT InfoNet Patient Assistant Fund (PAF) assists patients and caregivers with living expenses during treatment.

Grants are \$100-\$200. We cannot accommodate larger grant requests.

Who is eligible for Assistance

- **Patients who had an autologous transplant, an allogeneic transplant with a related donor or a haploidentical transplant** within the last 12 months
- **Allogeneic transplant patients**, regardless of donor type, who are 12-24 months post-transplant and are receiving ongoing medical care for **chronic graft-versus-host disease**
- Patients who have undergone **CAR-T therapy** within the last 12 months
- Patients who are having a **second transplant** or **CAR-T therapy**

Application Process:

- Application for funds **must be completed by a social worker or transplant center personnel** who certifies that the patient is in need of financial help
- Please **wait until day one** of transplant prior to submitting application
- **ALL sections** of the application form **must be completed** in order to be considered
- If you have questions, please call 888-597-7674

Evaluation/Decision

- Patient and Transplant personnel will be notified via email when application is received.
- **Fully completed applications** will be reviewed within two weeks of receipt. Incomplete applications will delay review.
- Applicants and transplant personnel will be notified via email of the decision following review.

Disbursement of Funds

- **RECENT CHANGE TO PROGRAM:** Funds will now be dispersed in the form of a check made out to the patient or caregiver and mailed to address indicated on form.

Please complete the following application with as much detail as possible with the patient/caregiver. Failure to complete the application in full will result in delay of review and funding.

Adult requesting Funds

This area is to be used for Patient/Adult Requesting Funds.

First Name of Patient/Adult Requesting Funds *

Last Name of Patient/Adult Requesting Funds *

Home - Street Address *

Home - Street Address Line 2

Home - City *

Home - State

Home - Postal Code *

Email - for Adult Requesting Funds

Birth Date - for Adult Requesting Funds *

Month

Day

Year



Relationship to Patient *

Relationship Other

Home - Phone Number *

Cell - Phone Number

If the person who is requesting the funds is not the patient. Please provide the following:

Patient's First Name

Patient's Last Name

Patient's Gender

Patient's Birthdate

Month

Day

Year



Diagnosis *

Type in disease to see list or select Other and complete the diagnosis description.

Diagnosis Description

If you did not see your Diagnosis on the drop down list or have additional information on the disease, please provide this information.

Primary Language Spoken in the home

Health Issues List

Do you currently have GVHD

What type of therapy did the patient have *

Bone Marrow/Stem Cell Transplant

CAR-T Therapy

Grant

People utilizing funds *

Indicate name and relationship of all people in household and any additional people who will utilize the funds.

Provide details why funding is needed. *

Include patient's current medical, living, family and financial situation. Please send additional information by email to marsha@bmtinfor.net or fax to 847-433-4599.

Itemize all SOURCES and AMOUNTS of current monthly household income *

Please include income of ALL members of the household. Include the amount of: Wages, Investment income, SSI, Disability payments, etc.

Amount Requested *

\$

Has the patient applied for funding from other organizations? *

No ▼

If Yes, list other organizations applied to and amount received

If patient is not awarded funds, how will s/he cover the expense? *

Will the check be send to a different address?

No ▼

First Name *

Last Name *

Degree/License *

Position at Transplant Program *

Phone Number *

Transplant Center Staff - Email *

Name of person making this affirmation and the date *

I affirm that the information provided in this application is true and complete, and I am recommending this patient for financial assistance.

Submit

Contact Us

Blood & Marrow Transplant Information Network (BMT InfoNet)
1548 Old Skokie Road Highland Park, IL 60035

Phone: 847-433-3313
Toll-free: 888-597-7674

help@bmtinfonet.org

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