Patient Application
Multiple Myeloma Transportation Assistance

275 Seventh Avenue, 22nd Floor, New York, NY 10001
1-800-813-HOPE (800-813-4673)

ALL APPLICANTS MUST BE PRE-SCREENED – CALL ABOVE NUMBER BEFORE SUBMITTING FORM

Step 1 – Personal Information

Patient Name

First Name _____ Last Name _____

Gender: ⬭ Male ⬭ Female Date of Birth: ____/____/_____ (month/day/year)

Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____

Email Address _____

Step 2 – Citizenship

Are you a US Citizen or Legal Resident with a Green Card or Work Visa?

⬭ Yes ⬭ No

Step 3 – Dependents

How many people live in your household who can be claimed as a dependent on your tax return? *(Including yourself – Example: You, Your Spouse and Your Child = 3)*

Number of Dependents

Step 4 – Income Information

Income from Your Tax Return – IRS Form 1040 or 1040EZ

Please locate your most recent tax return and enter your Adjusted Gross Income for either situation (A) or (B). The line for Adjusted Gross Income on the tax form is listed below.

(A) Single or Married Filing Jointly

Form 1040, Line 37 OR Form 1040EZ, Line 6 $

(B) Married Filing SEPARATELY

Form 1040, Line 37:

$	$	$
You (Patient)	Your Spouse	Total

Proof of Income

- ❑ **Please submit income verification for BOTH you and your spouse.**

  Signed copy(ies) of your most recent US Federal Income Tax Return (s) (IRS Form 1040 or 1040EZ) – the First 2 Pages ONLY.

- ❑ **For Individuals who did not file an Income Tax Return last year, you must submit ONE of the following:**

  A copy of your most recent Social Security/Disability Award Letter, Benefit Statement or monthly check

  A copy of your most recent paycheck/pension stub

  A copy of your Unemployment Check or Benefit Notification

PLEASE BLACKEN SOCIAL SECURITY NUMBERS FROM DOCUMENTS

Consent Information

I **promise** that:

All the information in this application, including all copies of documents proving my income, is true and complete.

I will not submit any claim for reimbursement to any insurance company or third party payer, including without limitation, Medicare or Medicaid, for any goods, items or services for which any portion of a transportation grant is used.

I will have my physician complete the Physician Verification Form which confirms my diagnosis of Multiple Myeloma and that I am in treatment for Multiple Myeloma.

I am authorized to sign this application.

I **understand** that:

The transportation grant, if awarded, is only if I am diagnosed with Multiple Myeloma and I am currently in treatment for Multiple Myeloma during the grant period.

The transportation grant, if awarded, is to be used solely for transportation to and or from my home to my doctor's office or medical facility for the treatment of Multiple Myeloma and not for any other purpose.

Cancer*Care* does not recommend, or arrange for the use of any particular product, practitioner, provider or supplier and I am completely free to change products, practitioners, providers or suppliers at any time and that I will not lose my transportation grant as a result of such change (unless I become ineligible for other reasons).

The transportation grant, if awarded, cannot be used to hire or obtain any vehicle or service that is considered "luxury" or "specialized transportation" such as limousines or ambulances.

I **understand** that:

Cancer*Care* is not in any way liable for the success or failure of my drug therapy or for any harm to my health that my medication may cause.

Cancer*Care* can ask for more information from me at any time.

Cancer*Care* can change or stop the program at any time for any reason with or without notice.

I **give** Cancer*Care* and my doctor permission to:

Check my information to make sure it is true and complete.

Share my information with the people helping with the Multiple Myeloma Transportation Assistance Program.

Contact me by mail or phone about Cancer*Care* and the Multiple Myeloma Transportation Assistance Program about other programs or services that might interest me.

I **understand** that I can call 1-800-813-4673 at anytime to:

Withdraw from the Multiple Myeloma Transportation Assistance Program.

Cancel my permission to use my information and withdraw from the program.

I **give** Cancer*Care* permission to contact the person named below with follow-up questions about my application (this applies only if someone completed this application for you).

If a family member or someone helped you with this application and you want them to answer questions for you, please give us his or her name and phone number.

Helper's Name _____ Helper's Phone (____) _____

Signature of Applicant

X_____ **Date** _____

Physician Verification Form
Multiple Myeloma Transportation Assistance

275 Seventh Avenue, 22nd Floor, New York, NY 10001
800-813-HOPE (4673)
Fax: 212-712-8495

Date:

Dear Physician or Health Care Professional,

Your patient has applied for enrollment to Cancer*Care* for transportation assistance for Multiple Myeloma Patients. In order to complete the enrollment process, we must verify the following information with you as the prescribing and/or treating physician. You may either return the form back to your patient or fax to number listed above. Please contact Cancer*Care* with any questions that you may have about this form.

Step 1 – Patient Information

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Diagnosis – MULTIPLE MYELOMA DATE of Multiple Myeloma Diagnosis _____

Step 2 – Health Care Professional Contact for Patient

PHYSICIAN'S First Name _____ PHYSICIAN'S Last Name _____

Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone ( ) _____ Fax ( ) _____

Other Contact Person _____ Position _____

Phone (if different) ( ) _____ Email Address _____

I certify that the patient named above has been diagnosed with Multiple Myeloma, is under my care for the treatment of such diagnosis and it is expected that medical or office visits are anticipated during the upcoming twelve-month period for the treatment of Multiple Myeloma.

Physician Signature: _____ Date:_____