

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

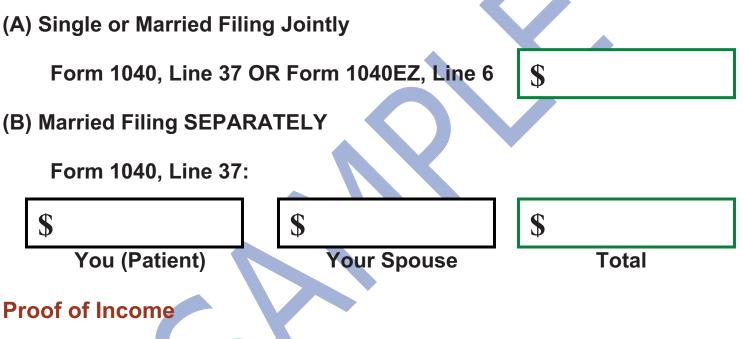
First Name	Last Name	
Gender: O Male O Female	Date of Birth:	_// (month/day/year)
Address		
City	State	Zin Codo
City		Zip Code
Home Phone ()	Cell Phone ()
		,
Work Phone ()		
Email Address		
Step 2 – Citizenship		
Are you a US Citizen or Legal Res	ident with a Green	Card or Work Visa?
O Yes	O No	
Sten 3 – Dependents		

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

Step 4 – Income Information

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

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



□ 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 <u>First 2 Pages</u> 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

Cancer Care Multiple Myeloma Transportation Assistance Program Page 3 of 3 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.

CancerCare can ask for more information from me at any time.

CancerCare can change or stop the program at any time for any reason with or without notice.

I give CancerCare 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 CancerCare 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 _____

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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 CancerCare 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 CancerCare with any questions that you may have about this form.

Step 1 – Patient Information	
First Name	Last Name
Address	
City	StateZip Code
Diagnosis – MULTIPLE MYELOMA	DATE of Multiple Myeloma Diagnosis
Step 2 – Health Care Profession	nal 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
	diagnosed with Multiple Myeloma, is under my care for the treatment of office visits are anticipated during the upcoming twelve-month period
Physician Signature:	Date:
/ClientID> //FirstName>//	astNamew Client #: "IDw August 15, 2012 * 8/15/2012 *