LOVE 4 LUKE TREATMENT & LOSS ASSIST PROGRAM APPLICATION

LOVE 4 LUKE CREATED THE TREATMENT& LOSS ASSIST PROGRAM because we are committed to meeting the most critical needs of those impacted by pediatric cancer and the loss of a child, parent, or spouse. The goal of this program is to help those struggling with the costs of pediatric cancer treatment & loss. While medical treatment and care will be the primary cost associated with pediatric cancer, there are other costs that prevent an individual from receiving the care they need.

For patients undergoing treatment with a household income at or below 200% of the Federal Poverty Level1 (pre-tax), a $300 award is available to help with treatment related expenses such as: rent or housing, utilities or bills, transportation to and from treatment, food or groceries, child or elder care to allow an individual to keep their appointments, home health care, medical equipment, and other medical expenses. Those undergoing active treatment for pediatric cancer are eligible to receive an award once every 12 months.

Instructions for Application ....

1. Complete the application
2. Obtain letter from patient's medical provider confirming patient is currently being treated for a form of pediatric cancer. Letter must be on official letterhead and dated within one year of application date.
3. Submit completed application and letter from medical provider to info@love4luke.org, 142 Addison Road, Glastonbury, CT 06033
   **Incomplete or unsigned applications will not be considered for funding
   ** Terms & Conditions ....

The data you provide herein will be used as set forth in Love 4 Luke Privacy Policy. Love 4 Luke, its employees and agents are hereby authorized to obtain and discuss medical, treatment, therapy, financial, and other information relating to applicant with the applicant's healthcare providers, pharmacy, employer, insurance company, and/or any other person or entity working with Love 4 Luke on the applicant's behalf for purposes of confirming the applicant's eligibility for the Treatment Assistance Program. Love 4 Luke may also use or disclose the applicant's personal information as necessary for Love 4 Luke to provide applicants with assistance under the program. Love 4 Luke may anonymize and de-identify applicant information and data and use such information for Love 4 Luke's own purposes, including to develop aggregate reports. Neither Love 4 Luke nor any of its employees or agents will disclose any applicant identifiable information to any third party except as provided above, as required by law, or as deemed appropriate by Love 4 Luke to investigate or resolve any potential fraud or audit irregularity.

Love 4 Luke Treatment & Loss Assis Program continuation is dependent on the availably of funds, and Love 4 Luke reserves the right to modify and/or discontinue the program at any time and without any prior notice to applicants. By submitting this application, the applicant agrees to hold Love 4 Luke harmless for any losses that arise, either directly or indirectly, from the applicant's to, and participation in, the Love 4 Luke Treatment Assistance Program.

For assistance with the application or for more information, contact us at 1-860-918-1683 or info@love4luke.org

[1] https://aspe.hhs.gov/poverty-guidelines
[2] https://www.love4luke.org/privacypolicy

LOVE 4 LUKE TREATMENT & LOSS ASSIST PROGRAM APPLICATION
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

....

First name*:________________________ Middle initial: _____ Last name*: _________________________
Address*: ____
City*:____ State*: _____________ Zip code*: __________
Phone number: Home __________________________Cell____
Email address: ____
Date of birth*: Month_________________________________ Day__________ Year___________________

*Required Gender: ☐ Female ☐ Male ☐ Gender Diverse ☐ Prefer Not to Answer

Race: ☐ Black or African American ☐ White or Caucasian ☐ Asian ☐ American Indian or Alaska Native ☐ Middle Eastern or North African (MENA) ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Answer Preferred language for future communications: ☐ English ☐ Spanish

PEDIATRIC CANCER INFORMATION

....

Date of pediatric cancer diagnosis:

____

Pediatric cancer type: ☐ (please specify):

____

Current stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐

cancer diagnosis: ☐ Yes ☐ No

Treatment(s) received in the past 12 months: ☐ Chemotherapy ☐ Radiation ☐ Surgery

☐ Other (please specify) ____________________________ Are you currently participating in a clinical trial for cancer: ☐ Yes ☐ No

LOVE 4 LUKE TREATMENT & LOSS ASSIST PROGRAM
APPLICATION HEALTH INSURANCE INFORMATION

....

Please indicate type of insurance the patient has. If patient is uninsured select, 'Uninsured' (check all that apply): ☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Charity Care ☐ VA Program ☐ Medigap or Medicare Supplement ☐ Unknown ☐ Uninsured Patient's monthly out-of-pocket costs for breast cancer treatment:

$ ________________________ Patient's monthly out-of-pocket costs for breast cancer treatment related prescriptions: $ ____

HOUSEHOLD FINANCIAL INFORMATION

....

Employment status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired Family income sources (check all that apply): ☐ Salary ☐ Social Security ☐ Pension ☐ Retirement Savings ☐ Short or Long-term Disability ☐ SSD (Disability) ☐ Unemployment ☐ Family or Friend Support ☐ Other (please specify):

____

Number of people in household*:_____ Current total annual household income*†:______________

*Required. †Eligible applicants must have pre-tax household income at or below 200% of the Federal Poverty Line (FPL) Persons in Family/ Household 200% of the 2021 Federal Poverty Line (FPL) 48 Contiguous States and D.C. Hawaii Alaska

https://aspe.hhs.gov/poverty-guidelines

HOW DID YOU HEAR ABOUT THE LOVE 4 LUKE TREATMENT & LOSS ASSIST PROGRAM?

.... ☐ Hospital/Healthcare Provider (e.g. Doctor, Nurse, Patient, Social Worker) ☐ Internet/Radio/TV ☐ Family/Friends/Another Patient ☐ Social Media ☐ Other (please specify):

____

142 Addison Road, Glastonbury, CT 06033 | 1-860-918-1683 | info@love4luke.org

LOVE 4 LUKE TREATMENT & LOSS ASSIST PROGRAM APPLICATION

FINANCIAL ASSISTANCE NEED ....

(Please select your most urgent treatment related financial need): ☐ Transportation ☐ Rent or Housing ☐ Utilities or Bills ☐ Food or Groceries ☐ Oral Treatment Medication (e.g. Chemotherapy, etc.) ☐ Child Care ☐ Elder Care ☐ Home Health Care ☐ Side-effect Management Medication (e.g. Pain, Anti-nausea, etc.) ☐ Durable Medical Equipment (e.g. Oxygen Tank, Walker, etc.)

PAYMENT INFORMATION ....

Please provide your banking information if you would like to receive awarded funds electronically. Electronic payments are more secure and can be processed and received faster than a check in the mail Account Type: ☐ Checking ☐ Savings
Bank Name: ____
Name on Account: ____
Routing Number: ____
Account Number:____
…………...

I, ____*, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the Love 4 Luke Treatment Assistance Program. By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

Patient Signature*: ____Date*: _______________________

If not patient: First name: _______________________ Last name: _______________________________

Relationship to patient: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member ☐ Social

Worker ☐ Patient ☐ Healthcare Provider ☐ Other (please specify):

____ *Required

142 Addison Road, Glastonbury, CT 06033 | 1-860-918-1683 | info@love4luke.org