The Sarcoma Alliance

Application to the Suzanne R. Leider Memorial
Hand in Hand Assistance Fund

A program to reimburse medical and other expenses directly related to getting a second opinion from a sarcoma physician (MD or DO) specialist

Please refer to the list of eligible expenses and application funding criteria and process at the last page of this form. You should check our website for the latest criteria and application. All fields must be complete and receipts included for an application to be considered.

Today's Date: _____

ABOUT YOU

Patient Name: _____

Date of Birth: _____

If Patient is minor, parent/ guardians name(s): _____

Address: _____

City/State: _____

Phone: _____

E-mail (optional): _____

Diagnosis (type of sarcoma): _____ Date of Diagnosis: _____

PHYSICIAN WHO PROVIDED THE SECOND OPINION

Physician: _____

Address: _____

City/State: _____

Office Phone/Fax: _____

E-mail: _____

The information contained in the application is confidential and will not be used for any purposes other than grant consideration.

(Revision date 03/11)

ABOUT YOUR INSURANCE

Are you insured? Yes / No (Circle)

If yes, provide company name and policy number: _____

If no, provide doctor/hospital documentation to support, e.g. copy of bill

Are you eligible for Medicaid/Medicare? Yes / No (Circle)

ABOUT YOUR EXPENSES

Please itemize eligible expenses and provide supporting documentation, e.g. copies of receipts. All applications must include evidence of a medical second opinion. Please see list of eligible/in-eligible expenses at the end of the application form. NOTE: If you are seeking reimbursement for travel expenses only, please provide supporting documentation that second opinion medical services were provided during the travel period. If you are seeking reimbursement for medical expenses and have insurance include any insurance paperwork to confirm insurance partial payment or denial. You may attach another sheet if necessary.

Date	Type of Expense	Amount Paid

Total Reimbursement Requested _____

PATIENT CONFIRMATION

I am the patient/guardian of the name patient being treated for _____(sarcoma type). I confirm that I have not received reimbursement for the above-noted expenses and I will not seek reimbursement for these expenses from other sources. I understand the Assistance Fund only reimburses for expenses related to getting a second opinion from a sarcoma specialist.

Signature: _____ Date: _____

PHYSICIAN CONFIRMATION

I am the provider of care to _____ in the treatment of _____(sarcoma type).

Name (Print) _____ State License #:_____

Signature: _____ Date: _____

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How did you learn about the Assistance Fund?

Internet Physician Nurse Support Group

Other (describe)

Are you interested in any of the following services/resources available through the Sarcoma Alliance? NOTE: You do not have to utilize other resources to be eligible for an Assistance Fund grant. Other support available:

Peer to Peer Client Literature Support Group Contacts

The Assistance Fund strives to help sarcoma patients with support for non-reimbursed expenses directly associated with obtaining a second opinion from a sarcoma specialist. Grants are awarded for eligible expenses as outlined below and there is a maximum award of $350 per patient for a period of one year from the date of the first application. The AF will award eligible applications based on available funds. Receipt of an application with qualifying expenses does not ensure that funding will be at the maximum level requested. Applicants will receive a letter of acknowledgement and grants are reviewed quarterly and notification of award will follow.

Eligible Expenses (please check what is included):

- **Required for all applications – evidence of medical second opinion, e.g. professional fee bill, insurance statement, appointment log**
- **Non-reimbursed portion of second opinion consultation from a physician (MD or DO) specialist**
- **Travel to/from second opinion including airfare, gas reimbursement or mileage (per IRS guidelines; $0.19/ mile in 2011)**
- **Parking**
- **Lodging – for travel to/from/during treatment/consultation center**
- **Meal expenses (per IRS guidelines) for patient (and for adult traveling with minor)**
- **Expenses of caregiver travel will be evaluated on a per application basis**
- **Long distance calls to arrange consultations/treatment**
- **Prosthetics**
- **Other**

NOT Eligible for Reimbursement:

- **Rent; Utilities**
- **Food expenses (except as noted above)**
- **Clothing; Personal incidental expenses**
- **Automobile repairs or payments**

PLEASE RETURN YOUR APPLICATION AND SUPPORTING DOCUMENTATION TO:

Sarcoma Alliance
775 E Blithedale, #334
Mill Valley, CA 94941

If you have any questions call 415/381-7236 or email info@sarcomaalliance.org

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