

## Application for Hand in Hand: The Suzanne R. Leider Memorial Assistance Fund (AF)

A program by the Sarcoma Alliance designed to reimburse out of pocket expenses related to a second opinion consultation with a sarcoma physician (MD or DO)



## ALL fields MUST be completed and receipts included for consideration; Please see website for latest version of application and current policies

Date of Application:			
PATIENT INFORMATION:		SECOND OPINION PHYSICIAN INFORMATION:	
Patient's Name:		Date of Second Opinion Consultation:	
Patient's Date of Birth:		Physician's Name:	
Patient's Street Address, City, State, Zip		Name of Facility, Address, City, State, Zip:	
Patient's Phone Number:		Physician's Phone Number:	
Patient's Email Address:		Physician's State License #:	
Type of Sarcoma:		Have you consulted with this physician before? Yes / No	Date of prior consultation:
Date of Diagnosis:		Were any tests ordered by this doctor as part of the	
Do you have health insurance?: Yes / No	Insurance provider and policy number :	consultation? Yes / No If Yes, please list:	
Guardian of Patient:			
without supporting docume apply and fill in the expense   Date of second of Physician confine  Evidence of second appointment log  Co-payment for many confiners of the confiner	ntation relating to the speed in the corresponding good in the corresponding good in the corresponding good in the corresponding good opinion medical good opinion provider, son-reimbursed second the invoice for charge good in the corresponding to the corresponding good in the corresponding good good in the corresponding good in the corresponding good in the corresponding good good good good good good good go	•	May be copies of arrier.  Sosts for the second opinion
	ement: \$ (	(to be filled in by AF Committee)	
	of miles from your he tion (airfare, train): \$_		
☐ Parking: \$_ ☐ Lodging: \$_ ☐ Meals: \$	Ψ_		
TOTAL REIMBURSEME	NT REQUESTED: \$		

The information contained in the application is confidential and will not be used for any purposes other than grant consideration. (Revision date 04/1013)

(All receipts for above related expenses must coincide with the date of the second opinion consultation)

## **PATIENT CONFIRMATION**

I confirm that reimbursemer	I have not received rent for these expenses	imbursement for from other sour	or the above-noted ex	(sarcoma type) penses and I will not seek Assistance Fund only arcoma specialist.		
Name of Patie	ent:			_		
Patient's/Guardian's Signature:				Date:		
PHYSICIAN CONFIRMATION  (Must be signed by physician providing second opinion or primary care physician below).  I confirm that the above named patient has seen me/the physician identified below (circle one) for a second opinion consultation on (date) to explore options relating to their diagnosis of (sarcoma type).						
Physician's Name (Print):				State License #:		
Physician's Signature:						
Second Opini	on Physician's Name	(if different) (Pr	int):			
How did you	learn about the Ass	istance Fund?				
Internet	Physician	Nurse	Support Group	Other (describe)		

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 up to the maximum award limit 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 confirming receipt of application. Grants are reviewed and approved on a quarterly basis, and notification of award will follow.

## 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