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**.*

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 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 Street 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 consultation? Yes / No If Yes, please list	
Do you have health insurance? Yes / No	Insurance provider and policy #:		
Guardian Name if Patient is a Minor			

NOTE: The AF only reimburses out-of-pocket expenses related to a <u>second opinion consultation for sarcoma</u>. The AF does NOT reimburse any out-of-pocket expenses related to the *treatment* of sarcoma. Please see our website (https://sarcomaalliance.org/resources/financial-assistance/) for details and links to other organizations providing financial assistance for out-of-pocket expenses related to treatment.

You must submit the following information and receipts for consideration of grant funds. **All receipts and supporting documentation MUST coincide with the <u>specified date of the second opinion consultation</u>.** Please check all that apply and fill in the expenses on the corresponding lines:

- ❒ **Date of second opinion consultation**: _____
- ❒ **Physician confirmation (page 2) must be filled out in its entirety**
- ❒ **Evidence of second opinion medical services for appropriate dates. May be copies of appointment logs, bill from provider, or statement from insurance carrier.**
- ☐ Co-payment (or self-pay) for non-reimbursed second opinion consultation: $_____
  (For co-pay reimbursement, you must include the invoice for charges related to your out-of-pocket costs for the <u>second opinion consultation</u>. Please be sure to include any insurance paperwork to confirm insurance partial payment or denial of consultation services).
- ☐ **<u>If you drove your own car</u>** specify # of miles from your home to the facility_____
- ☐ Other Transportation (for example: airfare, train fare, rental car, taxi): $_____
- ☐ Parking: $_____
- ☐ Lodging: $_____
- ☐ Meals: $_____

(For travel, lodging, and meals, we pay only for patient; if patient is a minor we will pay for guardian also.)

TOTAL REIMBURSEMENT REQUESTED: $_____

The information contained in the application is confidential and will not be used for any purposes other than grant consideration. (Revision date 1/2020)

PATIENT CONFIRMATION

In order to process this application, this section must be fully filled out and must be signed by the patient/guardian.

I am the patient/guardian of the named 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 reimburses **only for expenses related to receiving a second opinion** from a **sarcoma specialist**.

Name of Patient: _____

Patient's/Guardian's Signature: _____ Date: _____

PHYSICIAN CONFIRMATION

In order to process this application, this section must be fully filled out and must be signed by the physician providing the second opinion.

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).

Second Opinion Physician's Name (Print): _____ State License #:_____

Second Opinion Physician's Signature: _____ Date: _____

Primary Physician's/ Other Oncologist's Name *(Optional)* (Print): _____

How did you learn about the Assistance Fund? (please circle all that apply)

Internet Physician Nurse Social Worker 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 WITH ATTACHED SUPPORTING RECEIPTS AND OTHER DOCUMENTATION TO:

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

If you have any questions, please call 415.381.7236
or email info@sarcomaalliance.org

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