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Financial Grants Worksheet

Note: This is not the actual application

The answers you give in this worksheet can help your transplant team apply for financial grants for you. Please complete this worksheet as detailed as you can. Your answers help us match the best grant(s) for you.

Directions: Please fill out the entire Section 1. Then, review the scenarios in Section 2 and fill out any that apply to you.

Once complete, send this to your BMT Social Worker or the NMDP Patient Support Center (email below). They will submit an application on your behalf, and we will send them the decision within 5 business days.

If you have questions, our Patient Navigators can help.

- Call 1 (888) 999-6743
- Email patientinfo@nmdp.org

Note: For parents/caregivers who are completing this on behalf of the patient, questions with "I", "you" and "your" refers to the patient.

Section 1: General Information

a. About you

Patient name (first and last)	
Date of birth (mm/dd/yyyy)	
Diagnosis	
Transplant date, if applicable (mm/dd/yyyy)	
Recipient ID (RID), if applicable and known	
Caregiver or guardian name (if filling out on patient's behalf)	
Phone number	
Email address	

Demographics	
We ask for information like gender and race to make sure we're reaching a variety of people. You do **not** have to answer if you don't want to. This information does **not** impact our decision to give you a grant. Group data may be shared internally, but your name and individual answers will not be shared.	
What is your gender identity*? *Gender identity is your personal sense of self and gender, whether that be man, woman, neither, both or somewhere in-between.	
What is your race? Select all that apply.	☐ American Indian or Alaska ☐ Native Asian ☐ Black or African American ☐ Native Hawaiian or Pacific ☐ Islander White ☐ Prefer not to answer ☐ Not listed, please specify:
What is your ethnicity?	◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Prefer not to answer

Home and Temporary Address	
Home Address (Street Address, P.O. Box, Company Name, C/O)	
Home Address Line 2 (if applicable) (Apartment, Suite, Unit, Building, Floor, etc.)	
City, State	
Zip Code	

Are you staying somewhere else while getting treatment? **If yes, write your temporary address below, if known.**	○ Yes	○ No
Temporary Address (Street Address, P.O. Box, Company Name, C/O)		
Temporary Address Line 2 (if applicable) (Apartment, Suite, Unit, Building, Floor, etc.)		
City, State		
Zip Code		

b. Insurance and/or Indian Health Services (IHS)

☐ I do not have insurance or use IHS. If you checked this box, skip to **section c.**	
If you have medical insurance:	
Insurance company name	
Member ID, if known	
Group number, if known	
Issuing state, if known (State you receive your insurance from)	
If you have a second medical insurance:	
Insurance company name	
Member ID, if known	
Group number, if known	
Issuing state, if known (State you receive your insurance from)	
If you use IHS, Tribal Health Care Facility or Urban Indian Health Center:	
Facility name	
Facility state	

c. **Out-of-pocket costs**

Item	**Amount you pay each month** (not covered by your insurance)	**What are you having trouble paying for?** Select all that apply.
Air Travel		
Caregiver Costs (Travel, Food, Loss of Wages, etc.)		
Child Care		
Dental Costs		
Ground Travel (Gas, Parking, Bus, Train, Rideshare)		
Fertility Preservation		
Medical Costs (Insurance, Medications etc.)		
Permanent Housing (Mortgage, Rent, Utilities, Maintenance)		
Temporary Housing (Hotel, Airbnb, etc.)		
Other, please specify:		

d. Household income

Your household is everyone living in your home, who is either 18 and older **or** listed as a dependent on your taxes. It does **not** include:

- Roommates
- A legally separated or divorced spouse

How many people live in your household (including you)?	
☐ My household has no income. If you checked this box, skip to **section e.**	
Item	**Household income each month**
Employment (After-Tax Wages, Tips and Bonuses)	
Retirement Plan(s) (Pensions)	
Public Assistance	
Social Security	
Supplemental Security Income (SSI)	
Social Security Disability Income (SSDI)	
Unemployment	
Work Disability	
Other, please specify:	

e. Payment

Payee full name (Person who will receive the payment)	
Payee date of birth (mm/dd/yyyy)	
Payment preference	◯ Prepaid Visa card (arrives in 4 weeks) ◯ Check (arrives in 1-2 weeks) ◯ Direct deposit* (arrives in 3-4 business days) *If you choose direct deposit, you'll also need to complete a separate ACH form. If you have questions, our Patient Navigators can help. Call 1 (888) 999-6743 or email patientinfo@nmdp.org.
If you selected prepaid Visa or Check above, please tell us where to mail it:	
◯ Please use the **home address** listed in section a. ◯ Please use the **temporary address** listed in section a. ◯ Please use the address below:	
Address (Street Address, P.O. Box, Company Name, C/O)	
Address line 2 (Apartment, Suite, Unit, Building, Floor, etc.)	
City, State	
Zip Code	

f. Describe your situation

Please describe your situation and why you need help from a grant. Give any additional information we should know in making a grant decision. For example, loss of a job, out-of-pocket costs for housing, transportation and other expenses.

Please give as much detail as possible.

g. (Optional) Sharing your story

Our grants are supported through philanthropy. With your permission, your story can help us inspire the financial support that keeps this program running. Your answers will **not** affect your relationship with NMDP or how much money you're given.

I would like to…	Yes	No
Share my story above anonymously with NMDP employees and funders	○	○
Have someone from NMDP contact me to talk about sharing my story	○	○

Section 2: Additional Information*

*Most of our grants only need the information you provided in section 1. Two of our grants need more information. If neither scenario below applies to you, skip this section.

Which scenario applies to you (if any)? Select all that apply.	**Yes**	**No**
I received a transplant through NMDP more than 3 months ago and I'm getting treatment for chronic GVHD. If you checked yes, fill out **Section A** below.	○	○
I am enrolled or in the process of enrolling in a clinical trial (for a blood cancer or disorder) and I need help with travel expenses. If you checked yes, fill out **Section B** below.	○	○

A. Chronic GVHD treatment

Are you taking medicines to treat chronic GVHD?	○ Yes	○ No
How often do you go to the doctor for chronic GVHD?	○ More than once a month ○ Once a month ○ Less than once a month ○ Other, please specify:	

B. Clinical trials

National Clinical Trial (NCT) number	
Name of clinical trial facility/hospital	
Where is the clinical trial facility/hospital located? (City, State)	
How long will you be getting treatment in the clinical trial? (6 Months, 1 Year, 2 Years, etc.)	

Section B continued on next page >

Clinical trial travel costs	
How many times do you need to go to the clinical trial facility/hospital **each month?**	
How many nights do you need to stay in temporary housing* for **each visit?** (*hotel, Airbnb, etc.)	
How much does temporary housing cost **each night?**	
How much do you spend on food for **each visit?**	
If you use your own car to travel:	
How many miles do you travel to and from **each visit?**	
How much do you spend on parking for **each visit?**	
If you **don't** use your own car to travel:	
How much do you spend on transportation for **each visit?**	

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