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)

sarcoma alliance
Serving the sarcoma community since 1999

The Sarcoma Alliance Hand in Hand The Suzanne Renée Leider Memorial Assistance Fund

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		Physician's State License #:	
Patient's Phone Number:		Name of Facility, Address, City, State, Zip:	
Patient's Email Address:		Physician's Phone Number:	
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 number :		
Guardian of Patient:			

NOTE: The AF only reimburses out of pocket expenses related to a **second opinion consultation for sarcoma**. The AF does not reimburse any out of pocket expenses related to the *treatment* of sarcoma. Please see our website (http://sarcomaalliance.org) for additional resources 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. No funds will be approved without supporting documentation relating to the specified date of the second opinion consultation. Please check all that apply and fill in the expenses in the corresponding gray areas:

- ☑ **Date of second opinion consultation:** _____
- ☑ **Physician confirmation (page 2) must be filled out in its entirety**
- ☐ Co-payment for non-reimbursed second opinion consultation: $_____
  (You must include the invoice for charges related to your out of pocket costs for the second opinion consultation. Please be sure to include any insurance paperwork to confirm insurance partial payment or denial of consultation services).
- ☐ Mileage reimbursement: $_____ *(to be filled in by AF Committee)*
  Please specify # of miles from your home to the facility _____
- ☐ Other Transportation (airfare, train): $_____
- ☐ Parking: $_____
- ☐ Lodging: $_____
- ☐ Meals: $_____

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 09/2012)

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

PATIENT CONFIRMATION

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 only reimburses for expenses related to receiving a second opinion from a sarcoma specialist.

Name of Patient: _____

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

PHYSICIAN CONFIRMATION *(Must be signed by physician providing second opinion or primary care physician below).* Please submit the following documentation along with application:

- ☐ Invoice from doctors office and proof of payment (invoice date must coincide with date of consultation)
- ☐ Invoice from insurance provider for out of pocket expenses and explanation of partial payment or denial along with proof of payment (invoice date must coincide with date of consultation)

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: _____ Date: _____

Second Opinion Physician's Name *(if different)* (Print): _____

How did you learn about the Assistance 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

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