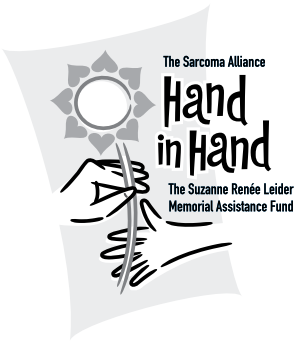




**sarcoma  
alliance**

Serving the sarcoma  
community since 1999



**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 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 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: \_\_\_\_\_

**ABOUT YOUR DOCTOR(S)**

Physician: \_\_\_\_\_ Primary/Secondary/Other (Circle)

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.

**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. 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.

<u>Date</u>	<u>Type of Expense</u>	<u>Amount Paid</u>
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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:

- Non-reimbursed portion of second opinion consultation
- Travel to/from second opinion including airfare, gas reimbursement or mileage (per IRS guidelines)
- 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
- Lodging – for travel to/from/during treatment/consultation center
- Long distance calls to arrange consultations/treatment
- Prosthetics
- Parking

### NOT Reimbursed:

- 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 [infor@sarcomaalliance.org](mailto:infor@sarcomaalliance.org)**

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