232 Green Avenue
Holmes, PA 19043
www.headstrong.org

The Nicholas E. Colleluori Patient Financial Assistance Grant Program

Guidelines

The HEADstrong Foundation makes available grants to patients undergoing treatment for blood cancers who are experiencing financial hardship. These Guidelines are intended to inform potential grant recipients of the standards and processes applicable to grants. Notwithstanding anything set forth in these Guidelines, all grant decisions are subject to the sole and absolute discretion of the HEADstrong Foundation, its officers and directors. The grant program may be altered, suspended or discontinued at any time. These Guidelines may be amended or modified at any time.

1. Grant Amounts: Up to $750 to (subject to availability of funds) to help offset living expenses, travel related expenses due to disease and/or medical expenses.

2. Eligibility Requirements: Grant recipients must meet the following eligibility requirements:
   a. Undergoing treatment at time of application for leukemia, lymphoma or myeloma
   b. Experiencing financial hardship as a result of medical condition
   c. U.S. resident

3. Referrals: Grant applications are only considered for applicants who are initially referred by a health professional (e.g., physician, nurse, or oncology social worker) familiar with the applicant's medical condition and course of treatment. All communications with the HEADstrong Foundation regarding grants or grant applications will be with the referring healthcare professional, and not with the patient.

4. Application: Prospective grant recipients must submit a completed Application in the form attached. The Application also requires a referral by a health professional (e.g., physician, nurse, or oncology social worker) familiar with the applicant's medical condition and course of treatment. Applicants must also certify they are eligible for a grant, according to these guidelines by providing annual income and employer.

5. Payments: Payments will be made to the provider only. Checks are issued on a quarterly basis.

6. Grants: Grants will only be awarded one time per applicant – renewal applications will not be accepted for additional financial support.

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Application

To be Completed by Patient: (Required)

Patient Name: _____
Last *First* *M.I.*

Address: _____City/State/Zip_____

Phone No's.: _____-_____-_____ _____-_____-_____ _____-_____-_____
Home *Work* *Cell*

E-Mail Address: _____Social Sec #:_____Date of Birth:__ /___/_____

How did you hear about HEADstrong Foundation? _____

Gender: ☐ Male ☐ Female Employer: _____Occupation: _____

Do you have health insurance? ☐ Yes ☐ No Do you have a prescription drug plan? ☐ Yes ☐ No
Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid (Title 19)? ☐ Yes ☐ No

Annual Household Income: ☐ $0 - $25,000 ☐ $26,000 - $50,000 ☐ Above $50,000

Please explain how a grant from the HEADstrong Foundation will assist with financial hardship caused by your medical condition (attach additional sheet if needed):

_____

_____

_____

_____

_____

The undersigned certifies to the HEADstrong Foundation that he/she meets the eligibility requirements of the Nicholas E. Colleluori Patient Financial Assistance Grant Program, and that all the information provided in or with this Application is true and correct.

Patient's Signature: _____ Date: _____

Printed Name: _____

If the patient is a minor, the undersigned parent or legal guardian of the patient signs on the patient's behalf:

Parent/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

HEADstrong Foundation
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The Nicholas E. Colleluori Patient Financial Assistance Grant Program

Application

To be Completed by Healthcare Professional: (Required)

Patient Name: _____
Last *First* *M.I.*

Patient Diagnosis: _____ Date of First Diagnosis: _____

Is Patient currently in treatment?: ☐ Yes ☐ No

Hospital or Other Healthcare Facility where Patient is being treated: _____

Address: _____

Name of Person Completing Form: _____

Title and/or Credentials: _____

Employer: _____

Address: _____

Work Phone No. _____ E-Mail: _____

Treating Physician (if different than person named above): _____

Address: _____

Phone No.: _____

The undersigned certifies to the HEADstrong Foundation that he/she has personal knowledge of the foregoing information and that it is true and correct.

Healthcare Professional Signature: _____ Date: _____

Printed Name: _____