

## Drs. Jeffrey and Isabel Chell Clinical Trials Travel Grant

With funding from Be The Match Foundation®, the National Marrow Donor Program®/Be The Match® provides financial help for patients (blood disorders/cancers), who need help paying the cost to travel for clinical trials. The **Drs. Jeffrey and Isabel Chell Clinical Trials Travel Grant**, in partnership with the *Jason Carter Clinical Trials Program*, helps qualified patients with the following travel costs:

- Patient and companion air travel: booked by dedicated travel agents
- Ground transportation: Gas/parking, and public/mass transit (bus/train/cab/etc.)
- Accommodations: hotel, temporary housing and incidentals

### Eligibility Requirements

- Patient must live in the United States (either resident or citizen).
- Patient needs a clinical trial for a diagnosis of blood disorder/cancer or immune-deficiency.
  - Any trial listed on the Jason Carter Clinical Trials Program website ([www.jcctp.org](http://www.jcctp.org)) is an eligible trial. If the trial isn't listed there, you can find out if it's eligible by contacting the Patient Grants Team at [patientgrants@nmdp.org](mailto:patientgrants@nmdp.org) or 763-406-8114. Generally, only interventional studies are eligible.
- Meets minimum travel cost requirements (see question 5 below).
- Household monthly net (take-home) income is within the income limits shown in this table:

# of persons in household	All states (except AK & HI), PR and DC	Alaska	Hawaii
1	\$3,015	\$3,765	\$3,465
2	\$4,060	\$5,073	\$4,668
3	\$5,105	\$6,380	\$5,870
4	\$6,150	\$7,688	\$7,073
Each additional person	\$1,045	\$1,307	\$1,203

To see if the patient is likely to be eligible, answer these questions before completing the application\*:

1. Does the patient have a blood cancer, blood disorder, or immune deficiency?  Yes  No
2. Is the patient's household income within the limits in the table above?  Yes  No
3. Is the patient enrolled in, or in the process of enrolling in, a clinical trial?  Yes  No
4. Is the clinical trial listed in the Jason Carter website?  Yes  No
5. Is at least one of the statements below true about the patient's travel needs?  Yes  No
  - a. Has to fly to get to the clinical trial.
  - b. Has to drive/be driven more than 300 miles a month for the clinical trial.
  - c. Costs \$150+ a month on bus/train/cab/parking etc. for the trial.
  - d. Costs \$150+ a month on accommodations (hotel, food etc.) for the trial.
6. Will someone on the medical team affirm patient need and submit application?  Yes  No
7. Does patient meet all the qualifications listed in the eligibility section?  Yes  No

**\*If you answered "No" to any of the questions you *might not* be eligible. However, answering "Yes" isn't a guarantee of eligibility - it is only an indication that you most likely are eligible. Patients and families should talk to their medical team, or contact Patient Support Center at 888-999-6743 or [patientinfo@nmdp.org](mailto:patientinfo@nmdp.org) with questions.**

- If you have government benefits (Medicaid, SSI etc.), make sure this grant won't negatively affect them.
- Air travel services are booked by a separate and independent vendor. NMDP doesn't operate, control, or provide services of the vendor. Hence, grant awardee agrees that NMDP isn't responsible for loss, accident, injury, delay, defect, omission or irregularity which may occur, whether because of any act, negligence or default of any company or person engaged in, responsible for, or connected to travel arrangements.
- Availability of grant depends on funding. Grant approval isn't guaranteed, regardless of eligibility.



OPAT# (Office use only):

Complete application thoroughly; missing information will cause delays or denial.

### A. Patient Information

Name (as it appears on legal ID):		
Address:		
Parent/guardian name (pediatric patients):		
DOB:	Sex: <b>Male</b> <b>Female</b>	Does patient live in the U.S.? <b>Yes</b> <b>No</b>
<b>Race</b> <input type="checkbox"/> American Indian or Alaska native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other:		<b>Ethnicity</b> Hispanic      Not Hispanic
Phone#:	Email:	
Diagnosis:		

### B. Clinical Trial Information

Are you already enrolled in a trial? <b>Yes</b> <b>No</b>	Trial#: NCT
Clinical trial name:	
Clinical trial facility/hospital name:	Is trial currently a primary treatment focus? <b>Yes</b> <b>No (explain):</b>
Reason for traveling: <input type="checkbox"/> Initial Consultation <input type="checkbox"/> Study Visits <input type="checkbox"/> Other <b>(explain):</b>	

### C. Insurance information

Is travel covered by patient's insurance? **Yes** **No** **Limited (explain):** \_\_\_\_\_

<b>Primary insurance name:</b>			
<b>Insurance Type</b>			
Medicaid-Managed Care	Medicaid-State	Private/Commercial	Tricare
Medicare Standard	Medicare-Advantage	No Insurance	
<b>Policyholder name:</b>			
<b>ID#:</b>	<b>Plan#:</b>	<b>Group#:</b>	

<b>Secondary insurance name:</b>			
<b>Insurance Type</b>			
Medicaid-Managed Care	Medicaid-State	Private/Commercial	Tricare
Medicare Standard	Medicare-Advantage	No Insurance	
<b>Policyholder name:</b>			
<b>ID#:</b>	<b>Plan#:</b>	<b>Group#:</b>	

## E. Household financial information

A household includes everyone who is in the same tax unit- wage earners and dependents - even if they don't live in the same house. How many people are in the patient's household? \_\_\_\_\_

<b>Please attach one of the following to verify income</b>		
<input type="checkbox"/> W2	<input type="checkbox"/> Social security statement	<input type="checkbox"/> Federal income tax return form
<input type="checkbox"/> 1 month pay stub	<input type="checkbox"/> Other:	

Type of income	Monthly income before diagnosis	Monthly income after diagnosis
Employment	\$	\$
Pension	\$	\$
Public Assistance	\$	\$
Social Security	\$	\$
SSI	\$	\$
SSDI	\$	\$
Unemployment	\$	\$
Work Disability	\$	\$
Other:	\$	\$
<b>Total:</b>	\$	\$

Monthly costs	
Please estimate all household costs, including mortgage/rent, food, utilities, non-trials transportation, insurance, entertainment etc...	\$
Please list all additional medical and clinical trials costs, including co-pays, and out-of-pocket costs etc.	\$
<b>Total monthly costs</b>	\$

## F. Payment information

<b>Tip:</b> If approved for air travel, our travel agents will contact you to book your flight.	
<b>Tip:</b> If approved for accommodations or ground transportation, a check will be sent to the payee you write below.	
<b>Tip:</b> <i>The payee should be someone who can <u>currently</u> handle the household finances and can speak to the bank, if necessary. We recommend you choose someone other than the patient.</i>	
<b>Tip:</b> The check will be sent to the <u>exact address</u> you write below. Double check to be sure it's readable and correct. Choose an address where you'll be able to get your mail if you are away from home during the clinical trial process.	
WDM? (office use only) No    Yes	Payee Name:
	Payee Date of Birth (mm/dd/yy):
	Address to mail check - mark here if address is recipient's address, as written in section A: <input type="checkbox"/>

## G. Travel information

What type of travel grant do you need? Check all that apply: <input type="checkbox"/> Patient air travel <input type="checkbox"/> Companion air travel <input type="checkbox"/> Ground transportation <input type="checkbox"/> Accommodations	
<b>Air Travel</b> - Date of Travel: - Departure Airport code: - Arrival Airport code: - Estimated date of return:	<b>Accommodation</b> <input type="checkbox"/> Hotel/Temporary housing <input type="checkbox"/> Food <input type="checkbox"/> Other: _____ Number of nights: _____ Cost per night: \$ _____
<b>Ground transportation:</b> - <b>Gas/parking:</b> Number of miles per month you drive to/from clinical trial? - <b>Bus/train/cab:</b> \$ amount spent going to and from clinical trials a month?	

## H. Patient/family signature

I/we certify that all of the information given in this application is true

Name Printed:	
Signature:	Date:
Relationship to Patient:	
<b>Patient/family comments (optional)</b>	

## I. Medical representative verification

This rep is who we will contact if we have any questions and who we will email with a grant decision.

Hospital/clinical trial rep name:	
Phone:	Email:
<b>Title</b> Social Worker                      Resource Specialist                      Trial Coordinator rs Nurse Coordinator                      Other:	
Signature:	Date:
<b>Medical representative's statement of need.</b> Address patient's need for grant assistance, as well as eligibility or acceptance into an eligible clinical trial. <input type="checkbox"/> <b>Attached</b>	