Formerly Children's Leukemia Foundation of Michigan®

The Blood Cancer Foundation of Michigan (BCFM) provides information, financial assistance, and emotional support to families affected by leukemia, lymphoma, and other malignant or potentially malignant disorders of the blood, bone marrow, and lymphatic system. Our services are free of charge and are available for both child patients and adult patients.

Families must complete this form to be eligible for BCFM's services. Please print clearly or type. Completed forms should be mailed to BCFM at PO Box 2477, Farmington Hills, MI 48333, faxed to (248) 530-3042, or emailed to patientservices@bloodcancerfoundationmi.org. Please call (800) 825-2536 with any questions or concerns.

Today's date:	**ALL FIELDS ARE REQUIRED**

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone: ( )	Cell Phone: ( )	Email:	Can your Patient Support Specialist text your cell phone? ❑ Yes ❑ No

Preferred Method of Contact: (please circle) Home Phone Cell Phone Email	Birth date: / /	Age:	Sex: ❑ M ❑ F	Patient is: (please circle) Child Adult

Street Address:	City:	State:	Zip:

Michigan County of Residence:	Race: ❑ American Indian or Native American ❑ Asian ❑ Black or African American ❑ Hispanic or Latino ❑ Middle Eastern or Arab American ❑ Multi-racial ❑ White or Caucasian ❑ Prefer Not to Answer ❑ Other/Not Listed ___________

Employment: (If patient is a child, please list parent/caregiver employment info)

❑ Employed- Employer Name______________________________ ❑ Unemployed ❑ Retired ❑ Disabled

❑ Student ❑ Other_______________________________

Veteran Status: ❑ Yes ❑ No

Household Income Level: (For informational purposes only. Services are not based on income.)

❑ $0-$10,000 ❑$11,000-$20,000 ❑ $21,000-$30,000 ❑ $31,000-$40,000 ❑ $41,000-$50,000 ❑ $51,000-$60,000

❑ $61,000-$70,000 ❑ $71,000-$80,000 ❑ $81,000-$90,000 ❑ $91,000-$100,000 ❑ Over $100,000

MEDICAL & INSURANCE INFORMATION

Diagnosis:	Diagnosis Date:	Bone Marrow/Stem Cell Transplant Date:

Treatment Center:	City:	State:

Health Professional Contact:	Title/Position:	Phone No:

Does the patient have insurance? (Please include Medicare/Medicaid) ❑ Yes ❑ No	Primary Health Insurance:	Secondary Health Insurance:

REFERRAL INFORMATION
How did you hear about BCFM's services?
❑ Social Worker ❑Doctor ❑ Nurse ❑ Patient Navigator ❑ Family Member ❑Friend ❑Internet
❑TV/Radio/Billboard ❑Other ________________________________

CAREGIVER INFORMATION				
Name of Primary Caregiver:			Relationship to Patient:	
Address: (if different from patient)	City:		State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Email:		
Should this person be the primary contact instead of the patient? ❑ Yes ❑ No				

ADDITIONAL FAMILY INFORMATION	
Total Number of People in Household: _____ Children _____ Adults	
List Names/Birthdates of Children Still Living in Home (other than patient):	
Name____________________ DOB___/____/____ Sex___	Name_____________________ DOB___/____/____ Sex___
Name____________________ DOB___/____/____ Sex___	Name_____________________ DOB___/____/____ Sex___
Name____________________ DOB___/____/____ Sex___	Name_____________________ DOB___/____/____ Sex___
Name____________________ DOB___/____/____ Sex___	Name_____________________ DOB___/____/____ Sex___

ADDITIONAL INFORMATION/COMMENTS

Please provide any additional information on your current needs: ____

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**In order to best support you, BCFM works with non-profit partners, and may confidentially provide your information to other non-profits or healthcare agencies and may request information about you from these agencies. BCFM will never sell your information or share it with solicitors.*

I certify that this information is true to the best of my knowledge and I agree to the terms listed above as of the date indicated below. I understand that The Blood Cancer Foundation of Michigan is a non-profit, community organization. Provision of services is subject to approval by the BCFM Board of Directors and may be discontinued at any time with or without notice. BCFM will contact me upon receipt of my completed application.

Signature___________________________________ Relationship to Patient __________________ Date: ______