HUMBLE BUMBLE PROJECT – PATIENT REFERRAL FORM

**Indicates required field*

SECTION 1: Patient and Family Information

Patient's Name*

Date of Birth* Sex* Male

Race American Indian or Alaska Native Ethnicity Not Hispanic or Latino

Name of Application Source*

Relationship to Patient*

Primary Phone Number*

Email Address*

Patient's Home Address*

_____

_____(City) _____(State)

_____(Zip Code) _____(County)

Family Size (including patient, parent/guardians, and siblings)*

Family member(s) name and age*

Estimated Annual Gross Income (for statistical purposes only)* Over $100,000

SECTION 2: Diagnosis and Treatment Information

Patients Diagnosis & Stage*

Date of Diagnosis*

Is the patient currently enrolled in a clinical trial?* No

If yes, does the clinical trial provide a stipend? No

SECTION 3: Medical Team Information

******APPLICATION MUST BE ACCOMAPANIED BY CONFIRMATION FROM A MEMBER OF THE PATIENT'S ONCOLOGY TEAM VERIFYING ACTIVE CANCER TREATMENT STATUS******

Healthcare Professional's Name and Title*

Healthcare Professional's Hospital*

Primary Phone Number*

Email Address*

SECTION 4: Support from other Organizations

Please provide the following:

1. Name of organization(s) the family has applied to,
2. Dates and assistance received from other organizations, if applicable,
3. If the family was denied assistance, please explain why, and
4. If the family has not applied to any other organizations, please explain why.

Organization Information*

SECTION 5: Summary of Request

What is the family requesting assistance for?*

The Bumble Bucks program provides up to $1,300 in assistance providing all eligibility criteria are met. Requests are limited to one per patient. Subsequent applications will be reviewed by the Board of Directors (BOD) on a case-by-case basis. Potential approval of any initial or subsequent application/allocation is at the discretion of the BOD and dependent upon the availability of funds. The Bumble Bucks program provides assistance for (including, but not limited to):

- Mortgage/Rent
- Utilities (electric, gas, water, sewer, telephone, internet, garbage)
- Fuel
- Groceries
- Maintenance/Repairs
- Installment payments (car payment, student loans)
- Child/pet care
- Other miscellaneous expenses which the patient/family can establish as being ordinary and necessary

Description and amount of request (i.e. $500 for electric, $250 for gas, etc.)

SUPPORTING DOCUMENTATION MUST BE SUBMITTED FOR ALL REQUESTS SUCH AS A COPY OF ELECTRIC BILL, ETC.

**********FOR OFFICIAL USE ONLY**********

Approved Denied

Reason for Denial

Amount of Assistance Allocated: