THE ICLA DA SILVA FOUNDATION

ICLA CARES – CRITICAL FUND PROGRAM

The Icla da Silva Foundation has been supporting bone marrow transplant patients and their families for the past 29 years.

Our mission comes from personal experience. Visit our website to learn more (www.icla.org)

Icla Cares is the Critical Fund Program of the Icla da Silva Foundation. We provide financial aid to blood cancer and sickle cell patients, and their families who meet our eligibility guidelines. This program helps cover several out-of-pocket expenses associated with a bone marrow transplant (see below: Use of Funds)

As a non-profit organization, we rely on the generosity of our financial donors. Program continuation is dependent on the availability of funds and the program could be modified or discontinued at any time if funding is limited or no longer available.

GENERAL GUIDELINES

To be eligible for the program:

- Patients must be a candidate for a bone marrow transplant, receiving medical treatment at a certified medical center in the United States.
- A Social Worker, Nurse, or Doctor at the medical center must provide a letter verifying a blood cancer or sickle cell diagnosis and the need for a bone marrow transplant to be considered for this program.
- Patient, Family or Social Worker must complete and submit the Patient Registration Form to be considered to receive assistance from the Icla Cares Program.
- Patient must have a household income that is at or below 400% of the current U.S. Federal Poverty Guidelines to be considered for financial support.
- Patients must be in active treatment or scheduled to receive a bone marrow transplant.

USE OF FUNDS

The Icla Cares Patient Critical Fund may be requested by patients and their families to cover costs associated with the following (allowable maximums):

- Compatibility (HLA) testing
- Transportation to receive treatment (up to $500)
- Housing/Lodging while in treatment (up to $1000)
- Caregiver expenses related to treatment (up to $750)
- Meal assistance during treatment (up to $150)

The maximum annual allotment per patient is $1000.

The Icla da Silva Foundation reserves the right to deviate from these Guidelines when special circumstances arise on a case-by-case basis.

DISBURSEMENT OF FUNDS

Funds are dispersed directly to either the patient or to a specific vendor. All expense requests must be accompanied with receipts.

P.O. Box 797186, Dallas, TX 75379
Phone : 212.593.1807 • Fax : 516.366.1434
www.icla.org • info@icla.org

APPLICATION CHECK LIST (based on Use of Funds Request)

General Requirement

- ☐ Complete the Icla da Silva Foundation Patient Information / Fund Request Form
- ☐ Letter from Doctor/Social Worker verifying a blood cancer diagnosis and the need for a bone marrow transplant

Compatibility (HLA) testing

- ☐ Letter from Doctor stating need to test siblings for compatibility (only applies if requesting funding for HLA Typing Compatibility).
- ☐ Icla da Silva Foundation's Release of Information Form completed and signed

Transportation

- ☐ Letter explaining need for financial support for transportation including:
  - Type of Transportation
  - Itinerary (including dates)
  - Amount requested

Housing/Lodging

- ☐ Letter explaining need for financial support for accommodation including:
  - Length of accommodation
  - Location
  - Amount requested

Caregiver expenses related to treatment

- ☐ Letter explaining need for financial support for Caregiver expenses including:
  - Need for caregiver support
  - Length of caregiver support
  - Amount requested

Meal Assistance

- ☐ Letter explaining need for financial support for meal expenses.

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PATIENT REGISTRATION / APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name: _____

SSN: ___ - ___ - ___ DOB: ___ / ___ / ___ Gender: _____

Ethnicity: ☐ Asian/Pacific Islander ☐ Caucasian. ☐ Hispanic/Latino ☐ Native American

☐ Black/African-American ☐ Prefer not to answer. ☐ Other _____

(Information will be used for statistical purposes only and will not affect eligibility.)

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ Cell phone: (___) _____

E-mail Address: _____

Annual Household Income: _____

Number of Occupants in Household: _____

Requested Grant (Please Choose One X) :

☐ Caregiver Expenses ☐ Housing (while in treatment)

☐ Travel (to receive treatment) ☐ Meals (while in treatment) ☐ HLA Testing

Amount Requested: $_____ (please provide copy of bills to be paid, if applicable)

Priority for grants is given to patients demonstrating the greatest financial need.

* Signature: _____ Date: ___ / ___ / ___

** By signing this application, you authorize the Icla da Silva Foundation to use your photograph, likeness (or your minor child's photograph or likeness, as applicable) and story, including your medical information, in activities related to raising and advancing public awareness of, and funds for, the mission of the Icla da Silva Foundation. You understand that your photograph, likeness, and story may be used in any media including but not limited to print, web, and social media. You also understand that you will not receive any monetary compensation from the Icla da Silva Foundations for authorizing the use of your photograph, likeness, and story.*

Forms can be emailed to info@icla.org or faxed to (516) 366-1434. Please include Patient Registration /Application in the subject.

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MEDICAL INFORMATION

(to be completed by a medical professional)

Patient Name: _____

Diagnosis: _____

Date of Diagnosis: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Physician Name: _____

Physician Phone: _____

Is the patient a bone marrow/blood stem cell transplant candidate? ☐ Yes ☐ No

Type of Transplant: ☐ Autologous ☐ Allogenic, related ☐ Allogenic, unrelated

☐ Cord Blood ☐ Other: _____

Transplant date (if known): _____

Please explain the medical condition and anticipated hospital stay:

_____

_____

Social Worker Name: _____

Social Worker Email: _____ Phone: _____

Social Worker Signature: _____ Date: ____/____/____

*Signature: _____

* *By signing this application, you are attesting to the accuracy of the information on both pages, to the best of your knowledge. Fraudulent applications may result in your institution being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.*

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