CHILDREN'S LEUKEMIA FOUNDATION OF MICHIGAN®
SERVING ADULTS & CHILDREN

Children's Leukemia Foundation of Michigan (CLF) 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 CLF's services. Please print clearly or type. Completed forms should be mailed to CLF at 27240 Haggerty Rd, Suite E-15, Farmington Hills MI 48331, or faxed to (248) 530-3042. 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. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone: ( )	Cell Phone: ( )	Email:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Preferred Method of Contact: (please circle) Home Phone Cell Phone Email	Patient is: (please circle) Child Adult

Street Address:	City:	State:	Zip:

County:

Race:
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic or Latino
❑ Middle Eastern or Arab American ❑ Native American or Other Pacific Islander ❑ White or Caucasian
❑ Prefer not to answer

Employment:

❑ Employed- Employer Name_____ ❑ Unemployed ❑ Retired ❑ Disabled ❑ Student
❑ Other_____

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

❑ $0-$10,000 ❑$10,000-$20,000 ❑ $20,000-$30,000 ❑ $30,000-$40,000 ❑ $40,000-$50,000
❑ $50,000-$60,000 ❑ $60,000-$70,000 ❑ $70,000-$80,000 ❑ $80,000-$90,000 ❑ $90,000-$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 CLF's services?

❑ Social Worker ❑Doctor ❑ Nurse ❑ Patient Navigator ❑ Family Member ❑Friend
❑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 Contact:	Relationship to Patient:		
Address: (if different from patient)	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Email:	

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 (please circle the extent to which you agree or disagree)

- ***I feel like I need more information about my/the patient's illness and surrounding issues.***

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments_____

_____

- ***My/the patient's illness has had an effect on our family's financial status.***

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments (please list specific expenses of concern, e.g. medical bills, transportation, utilities rent/mortgage, etc.

_____

_____

- ***I have/the patient has a good emotional support system to help me get through the stresses and strains of my/ the patient's illness.***

Strongly Disagree Disagree Neutral Agree Strongly Agree

Comments_____

_____

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

Signature_____ Relationship to Patient _____ Date: _____