PNH Patient COVID-19 Emergency Financial Assistance Fund Application

PNH Patients are eligible to apply for up to $350 in COVID-19 financial assistance through the end of December 31, 2020, per PNH Patient each year. By completing and submitting this form, you hereby certify that you have read the qualifying requirements of this Application and certify there is a financial hardship and need due to the COVID-19 pandemic. I agree with the following eligibility criteria in submitting this application:

- Patient must be a U.S. citizen or permanent resident and reside in the U.S. or U.S. territories.
- Patient must have a clinically confirmed diagnosis of paroxysmal nocturnal hemoglobinuria (PNH), attested to by the patient or care team member.
- Patient may be insured or uninsured.
- There are no income criteria.
- Patient does not need to have a COVID-19 diagnosis but must explain how the COVID-19/coronavirus pandemic has directly created a financial hardship related to their health or well-being.
- I understand there are very limited COVID-19 Financial Assistance funds and the Committee will solely decide on the final amount of funding up to $350/patient.

Signature: _____Date: _____

(Sign only if you agree with the above statements.)

I am a patient currently diagnosed as:

☐ PNH

☐ AA/PNH or AA/MDS/PNH

I am applying for a COVID-19 Emergency Financial Assistance grant and have the following financial challenges. (Provide a brief description of your total COVID-19 related financial hardship; reimbursement will only be up to $350.)

EXPENSE TYPE	ESTIMATED COST*	PLEASE EXPLAIN COST DETAILS (How did you arrive at this estimate?)
Unexpected unemployment costs		
Transportation		
Childcare		
Groceries (Delivery Fees?)		
Miscellaneous (Please explain)		
Total:		

PATIENT INFORMATION: (Confidential to PNH Patient Committee and AAMDSIF)

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Gender: Male ____ Female ____ Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

PARENT/GUARDIAN INFORMATION (if PNH Patient is under age 18)

Contact Name: _____

Contact Relationship to Patient: _____

Contact Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

DISEASE AND TREATMENT INFORMATION

Patient's Primary Diagnosis: _____Date of PNH Diagnosis: _____

Full Name of Current Treating Physician Name: _____

Phone number of treating physician: _____

REQUESTED SPECIALIST:

Specialist Full Name: _____

City: _____ State: _____

Phone: _____ Email: _____

CERTIFICATION

I hereby certify that this information is accurate and I agree to release this information to the PNH Patient Committee and its members.

Signature:_____

Name (Print):_____

Date:_____

SUBMISSION INSTRUCTIONS:

Scan/email to: PNH Patient Committee

Email: **pnhpatientcommittee@aamds.org**