Humble Bumble Project Patient Referral Form

* Indicates a field that is required.

Section 1: Patient and Family Information

Patient's First Name*

Patient's Last Name*

Date of Birth*

_____/_____/_____ (MM/DD/YY)

Ethnicity (For statistical purposes only)*

- African American
- Asian/Pacific Islander
- Caucasian
- Hispanic
- Native American
- Prefer not to answer
- Other

Patient's T-shirt Size*

Select One

Name of Application Source (Individual Providing Information to Healthcare Professional)**

Relationship to Patient*

Select One

Primary Phone Number*

Select One

Alternate Phone Number

Select One

E-mail (If the family does not have one, please provide your email)*****

Patient's Home Address*

_____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State)

_____ (Zip Code) _____(County)

Status of Parent/Legal Guardian(s) (If the Patient is a minor)

Select One

If separated/divorced, who has custody of the patient?

Family Size (Including patient, siblings, and parents/guardians)*

Family member names and ages*

Estimated Annual Gross Income (For statistical purposes only**)***

Select One

Is this patient covered by medical insurance (Answer will not affect eligibility)?*****

Select One

Section 2: Diagnosis and Treatment Information

Patient's Diagnosis and Stage*

Date of Diagnosis*

_____/_____/_____ (MM/DD/YY)

Is this patient currently enrolled in a clinical trial?*

Select One

If yes, does the clinical trial provide a stipend?

Select One

Section 3: Medical Team Information

Referring Healthcare Professional's Name (Name of hospital staff completing this form)*

Referring Healthcare Professional's Title*

Referring Healthcare Professional's Hospital*

Referring Healthcare Professional's Telephone*

Referring Healthcare Professional's E-Mail*

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: Travel Details

Destination Information:

Oncologist's Name*

Facility Name*

Facility Address*

_____ (Address 1)

_____ (Address2)

_____ (City) _____ (State)

_____ (Zip Code)

Date(s) of Travel*

_____/_____/_____ (MM/DD/YY) to _____/_____/_____ (MM/DD/YY)

If requesting lodging, number of nights stay

If requesting food, number of individuals in traveling party (maximum of three individuals – patient, caregiver, and caregiver support person)

Section 6: Summary of Request

What is the family requesting assistance for (Please check all that apply)?
Flight of the Humblebee provides up to $1,000 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. Flight of the Humblebee prepays travel expenses. The Humble Bumble Project is unable to reimburse for travel expenses already incurred. Please provide as much lead time on travel dates as possible.

Mileage – Allocation will be based on standard mileage rate of $0.58 per mile. Mileage will be provided for portal to portal travel only. The total number of miles will be determined by HBP by entering the patient's home address and the destination facility's address in MapQuest.

Airfare – Allocation will be for domestic air travel within the continental United States on commercial flights only (international travel, including Canada, is ineligible). Additional fees for checked baggage is the responsibility of the patient/family. Airfare will be provided for the patient and a caregiver, not to exceed the $1,000 maximum allocation.

Lodging – Allocation will be based on a standard per diem rate of $94 per night and the number of nights stay identified in Section 5. Lodging is for room and tax only, no incidentals.

Meals & Incidentals (M&I) – Allocation will be based on a standard per diem rate of $20 per day, per person. M&I will be provided for the patient, a caregiver, and a caregiver support person for a single calendar day of travel, unless otherwise noted in section 5. The amount received for the first and last day of travel will be based on a standard per diem rate of $10 per day, per person.

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

Approved Denied

Reason for Denial

Amount of Assistance Allocated: