Cooley's Anemia Foundation 2024-2025
50+ Health Maintenance Award Application

APPLICATION CHECKLIST

Your application must contain each of the following in order to be considered:

- Application form
- Signed form from physician verifying approval of program/treatment for which reimbursement is sought
- Copy of receipt for cost of approval/treatment for which reimbursement is sought
- Please note that at this time we are unable to reimburse you for the cost of iron chelators and transfusions.

Please note that the date of program/treatment for which reimbursement is sought must fall between July 1, 2024 and June 30, 2025 for reimbursement during this application period.

Return to escott@thalassemia.org or fax to (212) 279-5999 or mail to Cooley's Anemia Foundation, 50+ Awards, 330 Seventh Ave #200, New York, NY 10001.

COOLEY'S ANEMIA FOUNDATION
2024-2025 50+ HEALTH MAINTENANCE AWARD APPLICATION

Please print or type the information. Return to escott@thalassemia.org or fax to (212) 279-5999 or mail to Cooley's Anemia Foundation, 50+ Awards, 330 Seventh Ave #200, New York, NY 10001.

Name of Applicant: _____

Address: _____

City: _____ State:_____ Zip code:_____

Telephone number: _____

Email: _____

Please indicate thalassemia diagnosis: _____

Are you a resident of the United States? _____ Yes _____ No

What is your age? _____

Please tell us below about the program/treatment for which you are seeking reimbursement

What is the cost of the program/treatment for which you are seeking reimbursement (please note that CAF can only reimburse up to $500

_____

(Please be sure to include copy of receipt with application)

Applicant's Signature: _____

Date: _____

COOLEY'S ANEMIA FOUNDATION
2024-2025 50+ HEALTH MAINTENANCE AWARD
CONFIRMATION OF APPROVAL FROM PHYSICIAN

I, _____, confirm that I approve

(name of physician)

of the program/treatment for which _____

(name of patient)

Is seeking reimbursement from the Cooley's Anemia Foundation.

_____

(signature of physician)

_____

(date)