REQUEST FOR AID

(please print clearly)

Date of request: ________________

Patient's Name: ____________________________________ Age: _________________

Address: ____ ________________
(Street) (Apt/Suite)

___________________________________ __________ _______________
(City) (State) (Zip)

Telephone No.: ____________________________ Email: ________________________

Caregiver's Name: _____________________________ Phone No.: _______________

How did you hear about us: ____

Referring Professional's Name: ___________________________ Title: ____________

Phone No.: _____________________ Email: ___________________________________

Hospital/Clinic: ____

Attending Physician: ____

Diagnosis: ___________________________________ Date of Diagnosis: ____________

Type of treatment: ☐Surgery ☐Chemotherapy ☐Radiation ☐Other ________________

Estimated length of treatment if known: _____________________________________

Approximate annual household income: _______________ ☐ Individual ☐ Family

Approximate monthly medical expense: ____________________________________

Are you a US Resident? ☐ YES ☐ NO
Do you have health insurance coverage? ☐YES ☐ NO

TYPE OF AID REQUESTED:

________ PARKING REIMBURSEMENT
*Must include a copy of your receipts

________ GROCERIES UP TO $100.00

- Please select grocery store nearest you.
- ☐Market Basket ☐Stop & Shop ☐Other ____________

________ CELL PHONE REIMBURSEMENT UP TO $100.00
*Must include a copy of your latest statement

________ UTILITIES UP TO $200.00
*Must include a copy of your latest statement

________ HOTEL REIMBURSEMENT UP TO $200.00
*Must include a copy of your hotel invoice

YOU MAY REQUEST MORE THAN ONE ITEM BUT WE MAY NOT BE ABLE TO PROVIDE ALL.

THIS IS A ONE TIME GRANT PER YEAR. IF AFTER ONE YEAR YOU ARE STILL IN NEED OF ASSISTANCE PLEASE HAVE YOUR SOCIAL WORKER RESUBMIT A REQUEST FOR AID FORM.

Please tell us about yourself and why you are requesting aid:
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Applications that are not completed will not be processed.