Cancer Support V.I.

Financial Assistance Request Form

Patient Name:____

Spouse/Primary Caregiver: ____________________________________

Address: ____

Island/Zip:____

Email address: ____

Phone Number: ______________________cell: ____________________

Soc. Sec. No.: ____

Date of Birth: ____

Place of birth: ____

USVI resident ?: ____

Employer: ____

Employer address: ____

Employer phone number:____

Hours worked per week:____

Medical Insurance Co.:____

Medicare/Medicaid: ____

Medical Assistance: ____

Dept. Health Case Worker: ______________________________________

Case Worker phone number: _____________________________________

Requirement for all requests:

You must return copies of the following documents with this application:

1. Diagnosis confirmation Form must be completed and signed by both patient and Physician, or you must present a letter with diagnosis and treatment recommended provided by your Physician.

2. Proof of income- paycheck stub, letter from employer

3. Last filed Federal Income Tax return

4. Last statement for checking, savings, stocks, bonds, annuities, etc.

Gross Monthly Income

$____________Wages

$____________Social Security Income

$____________Unemployment

$____________Workers Compensation

$____________Child Support Alimony

$____________Public Assistance

$____________Food Stamps

$____________Pension / Retirement

$____________Annuity / Dividends

$____________Interest

$____________Cash from relatives

$____________Other – Please describe

____
____
____
____

$____________Total Income

Family Members in household	Birth date	Relationship

Request for Financial Assistance

Request for assistance: Please explain in detail what you are asking CSVI to help with. Please include details of any other financial assistance you are currently getting.

(Please use the back side of this page if you need more writing space.)

I have read and understand the above conditions to receive financial assistance. I also understand that all of the information on this application will be verified by the staff at Cancer Support VI and this will serve as a release for income verification and as a release to investigate my credit history. I swear all statements in this application are true and correct. All information provided will be held in the strictest confidence and will not be shared with any other group or entity. If any information submitted is found to be false it shall be cause for denial of this application and revocation of any previous or future financial assistance.

I accept that any decision made by CSVI with regard to my application is final.

____________________________________ ______________

Signature of Applicant Date

Please return form and documentation to:

Cancer Support VI
International Capital & Management Company
Attention: Charlene Kehoe
9800 Buccaneer Mall
#2B Box 35
St. Thomas, VI 00802- 2409

Fax: 340-777-1303

If your application is approved you must submit the invoice or bill for treatment or services to CSVI for payment. No monies will be paid directly to the patient.