



**Government of
The Virgin Islands of the United States
Department of Rehabilitation Services
Knud Hansen Complex-Building A/1303 Hospital Ground
St. Thomas, V.I. 00802**



Vocational Rehabilitation

(340) 774-0930 (Tele.)

(340) 774-7773 (Fax)

SPECIAL SERVICES

- Cancer Care
- Disabled Person Fund

REFERRAL INFORMATION

Name _____ Sex _____ Social Security No. _____

Date of Birth _____ Age _____ Place of Birth _____

Citizenship Status _____ Alien Regis. No. _____ Occup. _____

Home Address _____ Mailing Address _____

Telephone No. _____ person to notify in case of emergency _____

Referred * by _____ Date of referral _____

Statement of Disability _____

Type of Service requesting _____

Soc. Security Beneficiary No _____ Yes _____ Workmen's Compensation No _____ Yes _____

Medical Assistance No _____ Yes _____ Card Number _____

Health Insurance No _____ Yes _____ Name of Company(ies) _____

Where? _____ Name & Address of referee's physician _____

Name & address of referral source if an agency or organization _____

* Professional personnel referring clients, when possible, please obtain release from client or guardian and attach pertinent medical, psychiatric, psychological or educational information.

FOR VOCATIONAL REHABILITATION USE ONLY

Referral taken by:	Date	Assigned to:	Date

Note to counselors: As a professional courtesy to Doctors, professional services workers, agencies or organizations making referrals. Please fill out and send our "Report Back to Referral Sources" form at the end of the evaluation process.



GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
DEPARTMENT OF HUMAN SERVICES

DISABILITIES & REHABILITATION SERVICES
Knud Hansen Complex - Building A
1303 Hospital Ground
St. Thomas, Virgin Islands 00802

340
(809) 774-7773 FAX

340
Tel: (809) 774-0930

CANCER CARE PROGRAM
Application Form

Island _____

Date _____

Personal Information

Name _____ Social Security Number _____ - _____

Birthdate _____ Age _____ Birthplace _____

Citizenship _____ Alien Registration Number _____

Sex _____ Race _____ Marital Status _____ Religion _____

Address _____ Telephone Number _____

Occupation _____ Place of Employment _____

Work Telephone _____ Name of Spouse _____

Spouse's Occupation _____ Place of Employment _____

Emergency Contact _____ Telephone Number _____

Medical Information

Type of Cancer _____ Age diagnosed _____

Physician _____ Treatment Prescribed _____

Family Unit Living Under Same Roof

	Name	Age	Relation	Education	Occupation	Monthly Income
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____

Income & Expenses

Earned Income: Weekly _____ Bi-weekly _____ Monthly _____

Benefits: Social Security Disability _____ Workmen's Compensation _____

Food Stamps _____ Public Assistance _____

Other Income: Alimony _____ Child Support _____ Rentals _____

Retirement Benefits _____ Other _____

Liquid Assets & Property: Savings _____ Checking _____ CD'S _____

Trust Fund _____ Bonds _____

Insurance Coverage: Insurance Carrier _____

Medicare _____ Medical Assistance _____

Property owned: (value) _____ Houses (value) _____

Verification of Income & Resources

Bank _____ Date verified _____

Earned income verified: Check stubs _____ Letter _____ Date verified _____

Benefits verified: Social Security letter _____ Copy of Check _____ Date verified _____

Food Stamps: Certification notice _____ Date _____

Medical Assistance: Notice of Decision _____ Date _____

Workman's Compensation: Letter of verification _____ Check stub _____

Property verification: Tax assessed information _____ Date verified _____

Expenses: (Monthly)

Rent/Mortgage _____ Verified by receipts _____ Date _____

Utilities _____ Verified by receipts _____ Date _____

Telephone _____ Verified by phone bill _____ Date _____

Medical expenses _____ Identify the need (receipts) _____

Food & Clothing _____ *(Allow \$100.00 for each person per month)*

Transportation _____ Special diet _____

Medical Insurance premium _____

Total Expenses _____ Total Income _____

Allowed Deduction _____ Surplus _____ Deficit _____

Signature of Worker _____ Date _____

Signature of Applicant/Responsible Person _____ Date _____

DOCUMENT CHECK-LIST
CANCER CARE PROGRAM

Dear _____

Please bring in the documents indicated below so that we may process your case as soon as possible.

- | | |
|------------------------------------------|-----------------------------------------------------------------------|
| _____ Resident Alien Card | _____ Check Stub |
| _____ Rent or Mortgage Receipt | _____ Electric Bill |
| _____ Insurance Card | _____ Telephone Bill |
| _____ Medical Reports | _____ Social Security Card |
| _____ Tissue report | _____ Letter of denial/acceptance
from MCH |
| _____ Biopsy Report
denial/acceptance | _____ Letter of
from Medical Assistance
Medical Assistance Card |
| _____ Copy of Bank Account
Statements | |

Signature of Worker Date