CSVI
Cancer Support Virgin Islands

Sponsored Fund of CFVI Community Foundation of the Virgin Islands

CSVI Financial Assistance Request Form

Patient ID # _____

PATIENT INFORMATION

Patient Name _____ Spouse/Primary Caregiver _____

Mailing Address _____ Island/Zip _____

Email _____ Phone _____ Cell _____

Date of Birth _____ Place of Birth _____ USVI Resident _____

Employer _____ Employer Address _____

Employer Phone _____ Hours Worked Per Week _____

Medical Insurance ☐ Medicaid ☐ Medicare ☐ Private ☐ Military Program ☐ Uninsured

If insured: Provider _____ ID # _____ Group # _____

Date of Diagnosis MM/YYYY _____ Physician Name _____

Cancer Type _____ Other _____ Stage _____

Race (Optional) ☐ Black ☐ Caucasian/White ☐ Hispanic ☐ Asian ☐ Other _____

Dept. of Health Case Worker _____ Phone _____

Have you received financial assistance from CSVI in the past? _____

Gross Monthly Income	Family Members in Household	Date of Birth	Relationship
$_____Wages	_____	_____	_____
$_____Social Security Income	_____	_____	_____
$_____Unemployment	_____	_____	_____
$_____Total Income	_____	_____	_____
$_____Estimated monthly bills (Rent, mortgage, WAPA etc.)	_____	_____	_____

REQUIREMENTS FOR ALL REQUESTS

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

☐ Medical pathology report and/or the **Physician Verification Form** which must be completed and signed by your Physician.

☐ Copy of Insurance Card (only if insured).

☐ Signed CSVI Application (sign on next page).

How did you hear about CSVI?

_____

☐ I give CSVI permission to use my email address for future surveys in an effort to improve cancer care in the Virgin Islands.

REQUEST FOR FINANCIAL ASSISTANCE

Cancer Support VI Fund at Community Foundation of the Virgin Islands

The purpose of the Fund is to provide grants for cancer patients in treatment, who are residents of the USVI. Special consideration is given for non-residents living in the USVI who appeal to Cancer Support VI for assistance.

I understand, should I be approved for a grant (housing and/or airline or other financial assistance while I am receiving treatment); this grant will be a lump sum per patient per year. I will be responsible to book my own flight, hotel, pay invoices etc. I will use the grant to pay for air, hotel, treatment etc. Should I reach the allotted amount, I understand that I must make other housing/hotel and/or airline financial arrangements for the duration of my treatment; and I will be financially responsible for same.

Cancer Support VI Fund Per Patient Cap

- **CSVI will provide financial assistance for a patient up to five (5) years after initial diagnosis. If there is a recurrence, CSVI will assist again but will require a letter from your doctor stating continued treatment.**
- **If an application is approved, the patient must submit a letter requesting financial assistance. It is to include the reason for the funds (treatment, travel to treatment or assistance while in treatment) and a valid mailing address. This letter of request is required each year a patient is seeking financial assistance.**
- **NOTE: THE GRANT AMOUNT PER PATIENT IS DEPENDENT ON AVAILABLE FUNDS and may change.**

I have read and understand the above conditions to receive financial assistance. 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.

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 CSVI

EMAIL
anique.harrigan@cancersupportvi.com

MAIL
Cancer Support VI
Attn: Anique Harrigan
1600 Kongens Gade | St. Thomas, VI 00802

FAX 340.777.1303

For questions, contact Anique Harrigan,
CSVI Patient Advocate
MOBILE 340.514.8647