REQUEST FOR ASSISTANCE

Name_____Home Phone No._____

Street Address_____Cell Phone No._____

City/Town/State/Zip_____Work Phone No._____

Email Address:_____

Please explain your medical situation:

(If more room is needed, please attach a separate sheet)

Please explain your financial need:

____ Medical Expenses

____ Living/Household Expenses

____ Other Expenses
(If more room is needed, please attach a separate sheet)

please note the maximum financial award for any one request is $5,000 and is dependent on available funds

Patient's Name_____Date of Birth_____
(if different from above)

Parent's Name(s) if Patient under Age 18_____

Household Income: Current_____ Prior to Illness:_____

Patient Employment: Current_____(Yes/No) Prior to Illness:_____(Yes/No)

If yes, Employer's Name & Address_____
_____

Patient's Occupation: _____

Physician's Name_____Phone No._____

Physician's Address_____

If Patient is under Age 18, please complete Parents' information below:

Parents' Occupation _____

Parents' Employment: Current_____(Yes/No) Prior to Illness:_____(Yes/No)

If yes, Employer's Name & Address_____

_____

_____

How timely is your need?*

___Extremely Urgent ___As Soon As Possible ____Need within 2-3 Mos.

I attest by signature below, that the information above about my/my family's situation is true. I understand that I am providing this information for the purpose of receiving financial assistance from the non-profit organization, Tri-State Survivor.

_____	_____	_____
Name	Signature	Date

Please return this completed and signed form via US Mail to:

Tri-State Survivor
c/o Melissa Doak
70 Arbutus Trail
Charlestown, RI 02813

To expedite this Request for Assistance application, please **also** email signed application to:

mjdoak@tristatesurvivor.org

*Please note that our Board of Director's meets on a monthly basis and/or as needed for review of Requests for Assistance.