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 Citizen? YES NO

Are you a US Veteran? 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

_____ 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.

Please tell us about yourself and why you are requesting aid:

_____
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_____
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_____

Applications that are not completed will not be processed.

CONFIDENTIAL
BIGED.ORG, INC.
F: 617-723-2769