

# CANCER SOCIETY OF THE BAHAMAS

ASSISTANCE APPLICATION FORM			
APPLICANT INFORMATION			
Name:			
Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>			
Date of Birth: (dd/mm/yy)		Place of Birth:	
Current address:			How long?
City:		Island:	
P.O. Box:		E-Mail:	
Telephone Contact:		Home:	Cell:
Do you own a home? <input type="checkbox"/>		Do you rent? <input type="checkbox"/>	How much is your mortgage/rent monthly?:
Do you have children? Yes <input type="checkbox"/> No <input type="checkbox"/>		How many?	Sex and ages:
Do you have other dependents? Yes <input type="checkbox"/> No <input type="checkbox"/>			Relationship of dependents:
SPOUSE INFORMATION			
Name:			
Date of birth:		Nat. Ins. No.:	Phone:
Current employer:			
Employer address:			How long?
Phone:		E-mail:	Fax:
City/Settlement:		Island:	P.O. Box:
Position:		Weekly/Monthly wages?	
EMPLOYMENT INFORMATION			
Are you currently employed? Yes <input type="checkbox"/> No <input type="checkbox"/>		Nat. Ins. No.:	
Current employer:			
Employer address:			How long?
Phone:		E-mail:	Fax:
City/Settlement:		Island:	P.O. Box:
Date hired:			
Position:		Weekly/Monthly wages?	
Previous employer:			
Last date worked:		How long there?	Weekly/Monthly Earnings: \$
EMERGENCY CONTACT			
Name of a relative not residing with you:			
Address:			Phone:
City/Settlement:		Island:	P.O. Box:
Relationship:			
ASSISTANCE NEEDED			
Do you currently receive assistance? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, how much? Weekly: \$                      Monthly: \$	
Explain:			

## ASSISTANCE APPLICATION FORM

### PURPOSE OF ASSISTANCE NEEDED

Explain:

Do you have insurance? Yes  No  If yes, which type? Life  Medical  Both  Group Insurance

Name of Insurance Company:

### MEDICAL

Diagnosis:

Length of illness?

I hereby authorize investigation of all statements contained in this application. I hereby affirm that the statements made on this application are true and understand that misrepresentation or omission of facts called for on this form may cause this application to be denied.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**If the applicant is under the age of 18 years the parent/guardian would be responsible to sign off on the following:**

I hereby authorize/support this application process as the parent/guardian of the aforementioned applicant.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### INTERVIEW COMMENTS

Interviewer: \_\_\_\_\_ Signature: \_\_\_\_\_

Approved:  Amount Approved: \$ Rejected:

### PLEASE NOTE

All supporting documents such as medical diagnosis, referrals and treatments and the costs **MUST** be attached to the application.

### CRITERIA

1. Applicant must
2. Applicant must