CANCER CARING CENTRE ADMITTANCE APPLICATION FORM

APPLICANT INFORMATION		
Name:		
Marital Status: Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ]		
Date of Birth: (dd/mm/yy)	Place of Birth:	
Current address:		How Long?
City:	Island:	
P.O. Box:	E-Mail:	
Telephone Contact:	Home:	Cell:
Cancer Diagnosis:	Date:	Recommended Treatment:
Treatment Date to Start:	Treatment Date to be completed:	
Treatment Facility:	Emergency Contact:	
DO YOU HAVE ANY EXISTING MEDICAL CONDITIONS:		
IF YOU ANSWERED YES TO THE ABOVE PLEASE EXPLAIN:		
HAVE YOU EVER BEEN CHARGED WITH ANY CRIMINAL INTENT:		
IF YOU ANSWERED YES TO THE ABOVE PLEASE EXPLAIN:		

REFERENCE(S) AND TELEPHONE CONTACT(S) TO BE PROVIDED AND MUST INCLUDE: EMPLOYER, LANDLORD AND OTHER

1. _____
2. _____
3. _____

CAREGIVER INFORMATION		
Name:		
Date of birth:		
Relationship to Patient:		
Current Address:		How Long?
Telephone Phone:	E-mail:	
City/Settlement:	Island:	P.O. Box:
Availability of time to assist with Patient:		
DO YOU HAVE ANY EXISTING MEDICAL CONDITIONS:		
IF YOU ANSWERED YES TO THE ABOVE PLEASE EXPLAIN:		
HAVE YOU EVER BEEN CHARGED WITH ANY CRIMINAL INTENT:		
IF YOU ANSWERED YES TO THE ABOVE PLEASE EXPLAIN:		

A CAREGIVER MUST BE THE AGE OF 18 YRS. OR OLDER AND IDENTIFICATION MUST BE PROVIDED

EMERGENCY CONTACT
Name of a relative not residing with you:
Address:

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City/Settlement:	Telephone Contact:
Relationship:	

ASSISTANCE NEEDED

Do you currently receive assistance? Yes [ ] No [ ]		Phone:
Explain:	Island:	P.O. Box:
	If yes, how much? Weekly: $	Monthly: $

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:_____

APPLICATION COMMENTS

Interviewer: _____ Signature:_____
Approved: [ ] Rejected: [ ]

PLEASE NOTE

All supporting documents such as referrals from Oncology or Radiation Departments and treatments summary report **MUST** be attached to the application. In addition, please provide a copy of your NIB Card # or passport or drivers license – this would be for the patient and caregiver.