RIDE FOR HOPE TREATMENT ASSISTANCE
ADMINISTERED BY THE CANCER SOCIETY OF THE BAHAMAS

ASSISTANCE 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:
Do you own a home? [ ]	Do you rent? [ ]	How much is your mortgage/rent monthly?:	
Do you have children? Yes [ ] No[ ]	How many?	Sex and ages:	
Do you have other dependents? Yes [ ] No [ ]		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 [ ] No [ ]	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 [ ] No [ ]	If yes, how much? Weekly: $ Monthly: $
Explain:	

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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: _____

INTERVIEW COMMENTS	
Approved By:	
Amount Approved: $	
Rejected:	
Interviewer: _____	Signature:_____

PLEASE NOTE

All supporting documents **MUST** be attached to the application.
ONLY for persons that **DO NOT** have Medical Insurance.

SUPPORTING DOCUMENTS:-

1. Quotation(s) from medical facility regarding test, treatment to be carried out or a statement showing balance on your account.
2. Letter from Public Hospitals Authority or Doctor's Office stating diagnosis and treatment
3. A copy of General Pathology Report confirming diagnosis
4. A copy of Radiology Report (if available)