MEDICAL ASSISTANCE APPLICATION FORM

SECTION A – APPLICANT INFORMATION

1. Name of Patient: _____ _____ _____ (Mr/Miss/Mrs)
   Surname Christian Middle Initial

2. Mailing Address: _____

   _____

3. Telephone & email: (____)_____/(____)_____/ _____
   Home Mobile Email

4. Date of Birth: _____/_____/_____ 5. TRN: _____
   Day Month Year

5. Number of Children: _____ Ages: _____

6. Other Dependents (excluding children):_____

7. Occupation:_____

   (if retired, state what your previous occupation)

   Employment Status: ☐ Employed ☐ Self-Employed ☐Retired ☐Unemployed

   Name of Employer: _____ Salary/Wage:_____per _____

SECTION B – DETAILS OF DIAGNOSIS

1. Name of Doctor _____ Health Facility _____

2. Diagnosis ☐ Cancer ☐End Stage Renal Disease (ESRD)/Kidney Failure

   If Cancer, please state the type of cancer:_____

3. Please provide a brief description of illness (*eg. date of diagnosis, treatments completed etc*):

   _____

   _____

   _____

4. Is treatment available locally? ☐Yes ☐No if yes, Where: _____

5. Health Insurance ☐Yes ☐No *If yes, please state name of provider* _____

6. Cost of Treatment: _____ Amount of funding requested: _____

7. Other Fundraising Efforts: _____

_____

SECTION C – IF PATIENT IS A MINOR (APPLICABLE TO PATIENTS UNDER 18 YEARS)

1. Name of Parent/Guardian: _____ _____ (Mr/Miss/Mrs)
   Surname Christian

2. Relationship to Minor: ☐Mother ☐Father ☐Legal Guardian

SECTION D – ADDITIONAL CONTACT/NEXT OF KIN

First Contact Person

Name: _____ (Mr/Miss/Mrs)

Telephone: (____) _____, (_____) _____

Second Contact Person

Name: _____ (Mr/Miss/Mrs)

Telephone: (____) _____, (_____) _____

_____ _____

Signature of Patient/Legal Guardian *Date (dd/mm/yy)*

Please be informed that your request will be considered based on the availability of funds.

Application Checklist

In order to expedite your application, please ensure the following checklist is complete prior to the submission of your application

1. Doctor's Referral
2. Proforma Invoice for Treatment