MEDICAL ASSISTANCE APPLICATION FORM

SECTION A – APPLICANT /PATIENT 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 *(of children)*: ____________________

6. Other Dependents (excluding children):____

7. Occupation:____

   (if retired, state 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: ____________________ (Surname) __________________ (Christian) (Mr/Miss/Mrs)

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

3. Telephone: (____) ___________, (_____) __________ Email:_________________________________

SECTION D – ADDITIONAL CONTACT/NEXT OF KIN

First Contact Person	**Second Contact Person**
Name: _________________________ (Mr/Miss/Mrs)	Name: _____________________________ (Mr/Miss/Mrs)
Telephone: (____) ___________, (_____) __________	Telephone: (____) ___________, (_____) __________
Email:____________________________________	Email:____________________________________

___________________________________ ___________________________

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

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

Application Checklist

To expedite your application, please ensure the following documents are included in the submission of your application. The completed application form and documents can be submitted via e-mail to – health@chase.org.jm

1. Completed Medical Report Form
2. Proforma Invoice for Treatment

8 Belmont Road, Kingston 5
Tel: (876)908-4134; 908-4144; Fax:908-4139
Email: chase12@cwjamaica.com or health@chase.org.jm
Website: www.chase.org.jm

MEDICAL REPORT FORM

Please complete this form and include any clinical document relevant to the patient's condition to be attached to the patient application form for submission. Note kindly that missing information may result in a delay in the processing of the application.

SECTION A – PATIENT INFORMATION		
First Name:	Other Name(s):	Last Name:
Gender:	Date of Birth(dd/mm/yyyy):	
Patient Contact info:		

SECTION B- PATIENT CASE HISTORY
Reason for funding request:
Medical history/Clinical signs:
Patient diagnosis and stage:
Previous procedures and medications taken:
Prognosis:

Current treatment recommended:
Recommended length of time for treatment:
Cost associated with treatment:

SECTION C- REFERRING FACILITY /PHYSICIAN
Referring Physician
Practice/ Facility name:
Practice/ Facility address:
Office contact #:
Email:

SECTION D- ADDITIONAL RELEVANT INFORMATION

____

Signature

____

Date (dd/mm/yy)

____

Stamp/Seal of Physician/Facility