Request for Assistance

Name: ______________________________________Date of Birth: ________

F/M: _________

Street: ___________________________City: _________________________,NH

Zip____________ Phone #: __________________

E-mail ____

Amount of Request: $_____________

Timeline when needed: _____________________

Description of activity, services or items to be purchased:

____

____

Enclose a copy of the order or prescription from your health care provider and/or an estimate for service(s) not yet received or expense(s) not yet incurred.

OR

Enclose a copy of the bill for service(s) received or expense(s) incurred.

Who referred you to chill Cares?
Name: ______________________________Phone: _____________________

Email_____________________________Organization:______________________

Have you applied to chill Cares in the past? No_____ Yes _____ Year _______

Have you been diagnosed with cancer? No_____ Yes _____

The media frequently asks us for the personal stories of those we have helped. Would you be willing to share how chill Cares has helped you?

Yes _____ No _____

I understand that the chill Cares Foundation has final approval of this application and may take up to 30 days to process.

Signature: ______________________________________Date: _____________

For Treatment Center Representative to complete:

Name of Treatment Center:____

Representative's Name:____

Representative's Title: ____

Representative Phone: ________________ Email: _______________________

Representative's Signature:____

Please complete this form and have your Cancer return to chill Cares at info@chillcares.org subject: Assistance Request.