



בס"ד

**ROFEH CHOLIM CANCER SOCIETY**  
**768 BEDFORD AVENUE BROOKLYN, NY 11205**  
**TEL (718)722-2002 FAX (718) 473-3657**

**Dear Applicant,**

Enclosed find an application to request approval for charitable grants toward medical insurance premiums.

Please complete and return the application to the address above or via fax, along with the following supporting documentation:

- 1) A letter from patient's doctor confirming diagnosis and treatment plan.
- 2) Attestation Form signed by Rabbi with whom patient is affiliated.
- 3) A document indicating your policy's monthly premium amount i.e. monthly bill, plan benefit outline, new plan rate sheet etc.

Upon receipt of your complete application, our Application Committee will evaluate the patient's eligibility and inform you of their decision.

If your application is approved, payment will start the month we received the application and all documentation.

**WITH BLESSINGS FOR A SPEEDY AND COMPLETE RECOVERY**

**ROFEH CHOLIM CANCER SOCIETY**  
**APPLICATION FOR CHARITABLE GRANTS TOWARD MEDICAL INSURANCE PREMIUM**

PATIENT INFORMATION					
PATIENT ID	FIRST NAME	LAST NAME	SEX	BIRTHDATE	SOCIAL SECURITY NUMBER
ADDRESS			CITY	STATE	ZIP
				HOME PHONE	MOBILE PHONE
PLEASE PROVIDE FAX/ EMAIL (IF ANY) THAT CAN BE USED FOR ROUTINE CORRESPONDENCE				HEBREW NAME FOR REFUAH SHLEIMA:	
FAX	EMAIL				
SPOUSE/PARENT INFORMATION:					
SPOUSE OR PARENT NAME			BIRTHDATE		PHONE
LIST ANY CHILDREN, INCLUDING THOSE MARRIED OR NOT LIVING AT HOME: use blank sheet for additional space					
NAME	DOB	GRADE	MARRIED	PHONE	SCHOOL NAME (optional: info used for possible scholarship funds)
EMPLOYMENT/INCOME INFORMATION: (IF PATIENT IS MINOR, PARENT COMPLETE)					
ARE YOU EMPLOYED?		EMPLOYER'S NAME		OCCUPATION	MONTHLY INCOME
[ ] YES [ ] NO					
IS SPOUSE EMPLOYED?		EMPLOYER'S NAME		OCCUPATION	MONTHLY INCOME
[ ] YES [ ] NO					
BRIEFLY EXPLAIN YOUR FINANCIAL HARDSHIP OR REASON FOR REQUESTING RCCS ASSISTANCE:					
NOTE: WE WILL EVALUATE YOUR FINANCIAL HARDSHIP AS PART OF OUR ELIGIBILITY REQUIREMENTS. WE MAY INVOLVE YOUR ATTESTING RABBI IN OUR DECISION.					



**ROFEH CHOLIM CANCER SOCIETY**  
**APPLICATION FOR CHARITABLE GRANTS TOWARD MEDICAL INSURANCE PREMIUM**

**DISCLOSURE:**

I hereby acknowledge that Rofeh Cholim Cancer Society (here and after RCCS);

1. Is not receiving any money, fee, commission or thing of value in exchange for any assistance that it has provided me with respect to this application.

X  
\_\_\_\_\_  
Signature

2. Is not an insurance broker nor an insurance agent nor an insurance salesman nor affiliated with any insurance company.

X  
\_\_\_\_\_  
Signature

3. Does not provide any advice or recommendation with regard to any medical insurance policies.

X  
\_\_\_\_\_  
Signature

4. Does not provide any advice or recommendation with regard to the policy's coverage necessary for your circumstances.

X  
\_\_\_\_\_  
Signature

5. Is not a medical provider nor does RCCS provide medical advice or services.

X  
\_\_\_\_\_  
Signature

6. Sole aim is to help provide assistance towards the payment of medical insurance premiums for those who cannot afford to pay for same. Our ability to provide financial assistance to the applicant is subject to availability of its funds and other relevant criteria.

X  
\_\_\_\_\_  
Signature

7. The undersigned further understands and agrees that this application is entered into in full reliance on the accuracy and truthfulness of the information and documentation provided by the undersigned to this organization.

X  
\_\_\_\_\_  
Signature

8. The undersigned further acknowledges that enrollment with any medical insurance policy has not been based on any advice or guidance from RCCS.

X  
\_\_\_\_\_  
Signature

9. The undersigned further acknowledges that my selection of medical insurance coverage was based on medical providers, or brokers or other parties who are not affiliated with RCCS.

X  
\_\_\_\_\_  
Signature

**AUTHORIZATION:**

10. I, the undersigned, authorizes RCCS and its representatives to receive and review my protected health and other relevant information from and with my medical providers and or the above indicated clergyman and or employers and or medical health insurance companies to the purpose of evaluating this application, reviewing it at later point in time, as well as any continued financial assistance.

X  
\_\_\_\_\_  
Signature (patient or guardian if minor)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

**FOR INTERNAL USE:**

NUMBER OF MONTHS TO APPROVE:

COMMENTS:

SIGNATURE:

DATE:





# ROFEH CHOLIM CANCER SOCIETY

768 BEDFORD AVENUE BROOKLYN, NY 11205

TEL (718) 722-2002 FAX (718) 722-4757

## RABBI ATTESTATION / לרב הקהילה

NAME OF PATIENT \_\_\_\_\_ שם

ADDRESS OF PATIENT \_\_\_\_\_ כתובות

TEL. # OF PATIENT \_\_\_\_\_ טל

NAME OF RABBI \_\_\_\_\_ שם הרב הקהילה

NAME OF INSTITUTION / CONG \_\_\_\_\_ שם הקהילה

ADDRESS OF RABBI \_\_\_\_\_ כתובות של הרב

TEL. # OF RABBI \_\_\_\_\_ טל של הרב

### PLEASE CHECK OFF THE RABINICAL ORGANIZATION YOU ARE AFFILIATED WITH:

- |  |  |
|--|--|
| <input type="checkbox"/> AGUDATH ISRAEL OF AMERICA | <input type="checkbox"/> RABBINICAL COUNCIL OF AMERICA (RCA) |
| <input type="checkbox"/> AGUDAS HARABANIM          | <input type="checkbox"/> SEPHARDIC ASSOCIATION               |
| <input type="checkbox"/> CHABAD                    | <input type="checkbox"/> YOUNG ISRAEL                        |
| <input type="checkbox"/> HISACHDUS HARABANIM       | <input type="checkbox"/> OTHER _____                         |
| <input type="checkbox"/> ORTHODOX UNION (OU)       |  |

I hereby attest that the aforementioned patient, residing at the address indicated above, is affiliated with my institution / organization.

I am aware that (s)he has been diagnosed with cancer and that (s)he cannot afford to pay health insurance premiums.

SIGNATURE OF RABBI \_\_\_\_\_ חתימה

SEAL OR  
NOTARY OF  
SIGNATURE

I, the undersigned, authorize RCCS and its representatives to discuss my financial status with the above named clergyman for the purpose of evaluating my application as well as continued eligibility for charitable grants toward health insurance premiums.

SIGNATURE OF PATIENT \_\_\_\_\_ חתימה

DATE \_\_\_\_\_ תאריך