



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 mail the application to the address above along with the following supporting documentation:

- 1) Patient's medical info. (Diagnosis, prognosis, pathology report)
- 2) Attestations from clergyman with whom patient is affiliated.
(Must have signature and notarization)

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

INSURANCE INFORMATION:

NAME OF INSURANCE CARRIER	POLICY ID#	COVERAGE EFF DATE	MONTHLY PREMIUM COST
TYPE OF COVERAGE (SELECT ONE OF EACH)		INSURANCE CONTACT AT EMPLOYMENT (IF GROUP PLAN)	TEL
<input type="checkbox"/> HMO <input type="checkbox"/> POS <input type="checkbox"/> PPO <input type="checkbox"/> GROUP PLAN <input type="checkbox"/> DIRECT PAY/INDIVIDUAL PLAN <input type="checkbox"/> SINGLE <input type="checkbox"/> COUPLE <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> FAMILY		YOUR GROUP'S RENEWAL AND OPEN ENROLLMENT DATE:	
DO YOU HAVE MEDICAID, MEDICARE OR OTHER INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: ID#			

MEDICAL INFORMATION:

DIAGNOSIS- ATTACH DIAGNOSIS, PROGNOSIS, AND PATHOLOGY REPORT	TREATING FACILITY/HOSPITAL NAME:
TREATING SPECIALIST PHYSICIAN NAME	PHONE
PRIMARY CARE PHYSICIAN NAME	PHONE

TWO CLOSE RELATIVES OR RESPONSIBLE FAMILY MEMBERS OTHER THAN THOSE LISTED ABOVE

RELATIVE NAME	ADDRESS	PHONE#	RELATIONSHIP
1)			
2)			

TWO CLERGYMEN WHO KNOW PATIENT WELL:

NAME	CONGREGATION	DAY PHONE	EVE PHONE
1)			
2)			

HOW DID YOU HEAR ABOUT RCCS?	OPTIONAL: WHICH PUBLIC RELATIONS MATERIAL ARE YOU WILLING TO BE INCLUDED IN <input type="checkbox"/> PHOTOS <input type="checkbox"/> VIDEO <input type="checkbox"/> LITERATURE <input type="checkbox"/> NONE <input type="checkbox"/> ALL
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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

ROFEH CHOLIM CANCER SOCIETY
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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



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

DATE _____ תאריך

I, the undersigned, authorizes 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