MARTHA'S VINEYARD CANCER SUPPORT GROUP, Inc.

Po Box 2214 Vineyard Haven, Ma 02568
508-627-7958 OR 508-693-8296
www.mvcancersupport.org

APPLICATION FOR FINANCIAL ASSISTANCE

Financial assistance is awarded to year round island cancer patients and their families to help them meet emergency and temporary needs resulting from cancer-related illness and treatment. Because funds are limited, we ask that financial assistance be requested no more than twice in a 12 month period.

A letter from your physician is required along with this application indicating your diagnosis, date of diagnosis and treatment plan. In addition, it is necessary for you to provide receipts for any expenses this grant will cover.

The MVCSG Board meetings, where we review and approve the applications, are held every third Thursday of each month. However, we do require the paperwork by the second Thursday of the month. Please make sure your application is completely filled out, with the doctor's letter and all receipts enclosed. If your paperwork is not thoroughly completed and sent on time it will not be considered for that month's meeting.

All information is strictly confidential

1. Name of Applicant:_____ Date of Birth:_____
2. Mailing Address: _____
3. Street residence Address:_____
4. Telephone (H)_____ (W)_____ (C) _____
5. Email Address: _____
6. Your diagnosis _____
7. Treatment Plan _____
8. Where did you hear about the MVCSG? _____

Financial Request ~ Transportation:

SSA: _____ Bus:_____ Parking: _____ Taxi:_____ Ambulance:_____

Gas: 17c per mile, 160 miles round trip to Boston, $27.20 per trip: _____

Lodging: _____ Meals: _____ Prescriptions: _____ Medical Expenses: _____

Utilities: _____ Miscellaneous/other: _____

Rent/Mortgage, 1 reimbursement, Maximum $1000 per month: _____

Total Request: _____

Additional Information that may be helpful to us to evaluate your application. Use additional pages if needed.

_____

_____

_____

In order to ensure prompt consideration of your application, and to fulfill the requirements of our Non-profit status, we need to confirm your diagnosis, insurance eligibility, and treatment plans by requesting the following information:

1. A letter from your physician/healthcare provider indicating your diagnosis and your treatment plan, whether for yourself or your family member. Letter attached : _____

2. Receipts for expenses requested with this form: Receipts attached: _____

3. We would like you to review your health insurance coverage with local agencies or social workers to assure that you are receiving the benefits for which you qualify. If you have not already done this, we can help you find community resources. If you would like assistance, please check this box: ☐

I understand that this request is subject to confidential review by MVCSG board members and that in order to receive financial assistance, I am required to furnish the above information with this application. Finally, I affirm that all information I have provided is true and accurate.

Signature of Applicant: _____Date: _____

Applicant's name (please print): _____

Signature of person completing this form: _____

Name: (please print) _____Relation to Applicant:_____

Please send all supporting documents along with this completed application to :

MVCSG Inc. PO Box 2214 Vineyard Haven, MA 02568

Or via email (if form completed on line – you must still provide additional documents either as an attachment or via regular mail) Email to : annemariedonahue54@icloud.com

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MVCSG INC. board use only: **Revised May 1, 2023**

Names of board member review team: _____

Date of review: _____

Amount requested: _____ Amount Approved: _____

Check number: _____ Date of Check:_____

Other board members contacted: _____