REQUEST FOR AID

(please print clearly)

Date of request: _____

Patient's Name: _____ Age: _____

Address: _____ _____
(Street) (Apt/Suite)

_____ _____ _____
(City) (State) (Zip)

Telephone No.: _____ Email: _____

Caregiver's Name: _____ Phone No.: _____

How did you hear about us: _____

Referring Professional's Name: _____ Title: _____

Phone No.: _____ Email: _____

Hospital/Clinic: _____

Attending Physician: _____

Diagnosis: _____ Date of Diagnosis: _____

Type of treatment: ☐Surgery ☐Chemotherapy ☐Radiation ☐Other _____

Estimated length of treatment if known: _____

Approximate annual household income: _____ ☐ Individual ☐ Family

Approximate monthly medical expense: _____

Are you a US Resident? ☐ YES ☐ NO
Do you have health insurance coverage? ☐YES ☐ NO

CONFIDENTIAL
BIGED.ORG, INC.
F: 617-723-2769

TYPE OF AID REQUESTED:

_____ PARKING REIMBURSEMENT
*Must include a copy of your receipts

_____ GROCERIES UP TO $100.00

- Please select grocery store nearest you.
- □Market Basket □Stop & Shop □Other _____

_____ CELL PHONE REIMBURSEMENT UP TO $100.00
*Must include a copy of your latest statement

_____ UTILITIES UP TO $200.00
*Must include a copy of your latest statement

_____ HOTEL REIMBURSEMENT UP TO $200.00
*Must include a copy of your hotel invoice

YOU MAY REQUEST MORE THAN ONE ITEM BUT WE MAY NOT BE ABLE TO PROVIDE ALL.

THIS IS A ONE TIME GRANT PER YEAR. IF AFTER ONE YEAR YOU ARE STILL IN NEED OF ASSISTANCE PLEASE HAVE YOUR SOCIAL WORKER RESUBMIT A REQUEST FOR AID FORM.

Please tell us about yourself and why you are requesting aid:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Applications that are not completed will not be processed.