Jim Bashaw Memorial Cancer & Catastrophic Illness Fund Application

(Please note: applicant must be a resident of Franklin or Grand Isle County, VT)

Applicant Name: _____

Date of Birth: ____ /____ /____ **Gender:** _____ **Email:** _____

Home Phone: _____ **Work Phone:** _____

Applicants County: ☐ **Franklin County** ☐ **Grand Isle County** ☐ **Other:** _____

Mailing Address:

Street Address: _____

Address Line 2: _____

City: _____ **State:** _____ **ZIP Code:** _____

If your mailing address is different than your physical address, please specify:

Physical Address:

Street Address: _____

Address Line 2: _____

City: _____ **State:** _____ **ZIP Code:** _____

Do you have health insurance? ☐ **Y** ☐ **N**

Check the services you use: ☐ **Medicare** ☐ **Medicaid** ☐ **Commercial Insurance**

Number of adults you are financially responsible for: _____

Number of children under 18 you are financially responsible for: _____

Please list estimated household monthly income: _____

Total amount requested by applicant *(Please enter a value less than or equal to $500)***:** _____

Do you have an active/current cancer diagnosis? ☐ **Y** ☐ **N**

If yes, please specify your diagnosis: _____

Who is your treating physician? _____ **May we contact them?** ☐ **Y** ☐ **N**

Explain the need for this grant: _____

_____

_____

_____

_____

_____

NMC

133 Fairfield Street, St. Albans, Vermont 05478 • (802) 524-1280 • Northwestern.org

Method of grant distribution:

☐ **Mail to applicants address**

☐ **Mail to other address**

Specify mailing address and include name of recipient and account number: _____

_____

_____

_____

☐ **Need on-site distribution**

Specify your need for an on-site distribution: _____

_____

_____

_____

Would you be willing to share with us how this fund has helped you in the past? ☐ **Y** ☐ **N**

If yes, please share your story: _____

_____

_____

_____

_____

_____

Would you like to receive future notices on fundraising opportunities for the Jim Bashaw Fund? ☐ **Y** ☐ **N**

How were you made aware of this fund? ☐ Friends & Family ☐ Social Worker ☐ Oncology Care Manager

☐ Other Medical Staff ☐ Hospital ☐ Website ☐ Online Media ☐ Other

I affirm that all information provided in this application is accurate to the best of my knowledge. I authorize Northwestern Medical Center to verify any given information as needed to determine eligibility.

Applicant Signature: _____

Mail completed form to:
Care Management Department - Jim Bashaw Fund
133 Fairfield Street, St. Albans, Vermont 05478
or **fax to:** (802) 524-8908

For more info, please call the Care Management Department at – (802) 524-8479
We will do our best to process applications quickly, especially those that are urgent,
but please note that the committee may take up to 30 days.