

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: _____



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:

Jennifer Hauptman, Care Management Department
133 Fairfield Street, St. Albans, Vermont 05478
or **fax to:** (802) 524-8908

For more info, please call Jennifer Hauptman, MSW, LICSW – (802) 524-1082

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.

