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: ____________________

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Method of grant distribution:

☐ **Mail to applicants address**

☐ **Mail to other address**

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

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☐ **Need on-site distribution**

Specify your need for an on-site distribution: ______________________________

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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: ______________________________

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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:
Northwestern Medical Center, ATTN: Denise Smith
133 Fairfield Street, St. Albans, VT 05478

For more info, please contact Denise Smith at (802) 524-8913
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.