APPLICATION FOR ASSISTANCE

(Please Print)

Date:						
PERSONAL INFORMATION						
Applicant's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street address:		Home phone no.:		Birth date:	Age:	Sex: ❑ M ❑ F
City:		Postal code:			Phone:	
e-mail:	Name of Spouse /Partner:					
Age(s) of Dependent children:	Current Employer:			Employer phone no.: ( )		
PLEASE ATTACH YOUR RESUME						

MEDICAL INFORMATION
Family Doctor: Phone:
Address:
Nature of Medical condition:
Please provide supporting documentation.
Details of Medical coverage - include any benefit payments:

FINANCIAL INFORMATION			
Total FAMILY income (monthly): (list all sources) TOTAL MONTHLY INCOME : $_____	Savings: $	Assets: $	Other:
Total FAMILY expenses (monthly): list all amounts - Mortgage / Rent: Utilities: Food: Medical costs: Transportation: Other: TOTAL MONTHLY EXPENSES: _____			

ASSISTANCE REQUESTED			
Equipment or item being requested:	Cost of equipment: $	Amount requested: $	Notes:
List others sources of funding explored:			

Please summarize how assistance from the BCHF will benefit you – please attach a letter of support if applicable:
Applicant's signature:

A COVER LETTER PROVIDING DETAILS OF WHY AND WHAT SUPPORT YOU NEED WILL SPEED UP THE APPLICATION PROCESS
ANY RELEVANT MEDICAL INFORMATION FROM YOUR DOCTOR THAT WILL HEL US UNDERSTAND YOUR SITUATION SHOULD BE ATTACHED.

COMPLETED APPLICATIONS CAN BE E-MAILED, FAXED OR MAILED.