Cancer Outreach Program

Financial Reimbursement Application

Please allow up to four weeks to process.

All information on this application is CONFIDENTIAL.

Deliver to hospital front desk OR
Mail to: Mona Logan, Case Management
P.O. Box 660, Mammoth Lakes, CA 93546
phone 760-924-4211, fax 760-924-4123

Name:	Birthdate:	
Physical Address:	City/State/Zip:	
Mailing Address:	City/State/Zip:	
Main phone:	Alternate phone:	Email:
Diagnosis:	Date of diagnosis:	
Active treatment/maintenance (circle one)	Dates of medical appointments:	
Physician name and contact info:		
Please describe assistance needed:		
Are you receiving additional funding? Yes/No	If yes, from whom?	
How did you hear about us?		

Reimburseable with ***original, itemized*** receipts: Gas with receipt, Lodging up to $200 a day,

Food - $50 a day for patient, $25 a day for one accompanying caregiver *(no reimbursement for alcoholic beverages)*

	example: 2/14	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Lodging	*$200.00*							
Gas	*$45.00*							
Food	*$10.00*							
	$15.00							
	$25.00							
Daily Total	$295.00							
						Total requested:		

If total requested is above amount you have remaining for year, please specify extenuating circumstances and we will be happy to review and consider your request:

Please double check prior to submission - reimbursement cannot be processed without:
__ this application form __proof of appointment(s) __original, itemized receipts

I have read and understand this form. I have provided correct and complete information.

I give Mammoth Hospital permission to contact my other cancer providers.

Applicant signature: **Date:**

For Office Use Only:

The Cancer Outreach Committee has determined this applicant is eligible for assistance.	Total:
Board Chair Signature: Date:	Remaining: