# Cancer Outreach Program

Financial Reimbursement Application

Applications must be submitted within 60 days of appointment.

Please allow up to four weeks to process application.

All information on this application is CONFIDENTIAL.

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

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:

Are you receiving additional funding? Yes/No | If yes, from whom?

How did you hear about us?

**Expenses are reimburseable for the day of the appointment and one day before and after for travel.**

**Extra days require a physician's note explaining medical necessity. Daily limits are $200 for hotel,**

**$50 for patient meals, $25 for caregiver meals *(no alcoholic beverages)* , and gas/parking fees/tolls per receipt.**

| | *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:

*Please note that this fund is available to those who work or live in Mono County. *There is an annual limit available to each applicant of $1500 for maintenance visits or $4000 if you are in active treatement. *Documents bolded below must be submitted to us within 60 days of the visit you are requesting reimbursement for. *If you are requesting an annual overage exemption, please let us know the circumstances:

***Please double check prior to submission - reimbursement cannot be processed without:***
***__ this application form __proof of cancer related 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 cancer providers if additional information is needed.

**Applicant signature:** **Date:**

**For Office Use Only:**

Application updated 2.17.2022

The Cancer Outreach Committee has determined this applicant is eligible for assistance. | Total:

Board Chair Signature: Date: | Remaining: