

REQUEST FOR FINANCIAL ASSISTANCE

(Please attach referral & please print clearly)

Branch:	
First Name:	Surname:
Home Phone:	Mobile:
Email:	Date of Birth (Optional):
Address:	
How did you hear about Can Assist?	
Type of Financial Assistance: Your local Can Assist Branch may elect to support you with contributions toward one or more of the following areas: accommodation costs, medical bills, utilities, travel. Please indicate below the kind of support you require.	
Financial Support(s) required (please nominate an option below): <input type="checkbox"/> Contribution towards costs associated with cancer treatment <input type="checkbox"/> Direct payment of a bill/invoice (please ensure the bill/invoice is unpaid and attached to form)	
If a contribution, please supply your banking details:	
BSB:	Account No: Account Name:
Type of Cancer:	Current Cancer Treatment:
Health Care Professional:	Treatment Facility:
Signature*:	Date:

FOR BRANCH/OFFICE USE ONLY: CONFIRMATION OF FINANCIAL ASSISTANCE

Client Number:	Approved: Yes / No
Financial Support(s) required (please nominate an option below): <input type="checkbox"/> Branch has provided a contribution toward. Total payment \$ Total of all assistance provided \$ <input type="checkbox"/> Branch has paid a bill/supplier directly. Total payment \$ Total of all assistance provided \$ <input type="checkbox"/> Branch has paid/ made a contribution via cheque. Total payment \$ Cheque no. Total of all assistance provided \$	
Payment confirmed:	Date Assistance Provided:
Approving Branch Executive (Print Name)	Approving Branch Executive (Print Name)
Signature:	Signature: