Fairview and Area Palliative Care Society

Request for Financial Assistance

Requests for financial assistance are considered on a case-by-case basis. Fairview & Area Palliative Care Society will not fund medications.

Initials of person requesting financial assistance: _____

DOB: _____ Home Community: _____

Diagnosis:_____

_____

_____

Name of Healthcare Professional:_____

Signature of Healthcare Professional: _____

Date of Request:_____

Item Being Requested: _____

_____

_____

_____

Total Cost of Item: _____

Third party funding:_____

Funding amount requested: _____

Authorization of funds by Fairview Palliative Care members:

_____ _____
(printed name) (signature)

_____ _____
(printed name) (signature)

_____ _____
(printed name) (signature)

$_____ paid to _____

by treasurer _____on _____
(name) (date)