בס"ד

Date_____

Medical / Financial Assistance Form

Chaverim
Israel Family Services

Name of Patient _____ Age _____ ☐Male ☐Female

S.S. # ____ - ____ - _____ Medication _____ Daily Dose _____

Short discription of Patient condition, and assistance needed _____

_____

_____

_____

Name of person filling out the form _____

Relation to patient _____ Phone # _____ - _____ - _____

Contact Info: Email address _____

Name of Doctor or Facility of Treatment _____

Address _____ City _____ State _____

Zip Code _____ Phone # _____ - _____ - _____

Name of contact person _____ Position _____

Total treatment cost $_____ . ____ Requesting amount from CIFS $ _____ . ___

Bank _____ Bank account # _____

Routing # _____ Swift Code / Iban _____

Bank Address _____ City _____ State _____

Zip code _____ Name of Bank account holder _____

*** Please send along with this form all relevant medical documents and bills/invoices.**

**** Chaverim IFS will not make a decision without supporting documents.**

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Office use: Date of discussion _____ Ref # _____ / ____ Decision _____