Carson Valley Medical Center Hospital Foundation
Pink Ribbon Fund Application for Patient Assistance - Medical Expenses

Patient Information

Patient Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ DOB: _____

Please explain the reason for this request and the amount of assistance being requested. Feel free to attach documentation to support your application.

_____

_____

_____

_____

_____

_____

To the best of my knowledge, I declare that all of the information provided in this request is true and correct.

_____ _____

Patient Signature Date

I have reviewed this information with the patient listed above, and have determined that this patient meets the criteria to receive assistance from CVMC Hospital Foundation (include an assessment of other funds/assistance that may be available to patient).

_____ _____

CVMC Patient Financial Counselor Date

CVMC Hospital Foundation Use

Application for assistance approved? YES NO

If no, please explain:

_____

_____

_____ _____

Processed by (signature) Date

This form goes to CVMC Patient Financial Counselor – 775.783.3080