



Jamestown, RI Medical Fund Medical Assistance Form			
Applicant Information			Date: _____
Name:			
Address:			
Own/rent		Monthly payment	
Employment information			
Current employer			
Employer address			
How long have you worked there?		How are you paid? <i>Circle one</i> Hourly Salary	Other income:
Monthly expenses			
Insurance information			
Provider:			
If insured, are expenses on this form covered? expense? Yes No		% covered	

Assistance Requested (please list each health care provider separately, include a separate sheet if necessary)	
Medical bills (i.e. X-Ray)	
Doctor bills	
Prescriptions	
Therapy	
Other	
Assistance Requested is:	One Time Weekly Monthly Other

Please complete second page of application

Please describe your medical problems (attach extra pages as needed):

Please explain why assistance is required:

Signature of Applicant
& Date

*All applications are reviewed in confidence of the Jamestown Medical Fund.
Please note that assistance is made **directly to the service provider on your behalf.**
The JMF requires you to investigate assistance and reduced billing programs offered by the
doctor, hospital or service provider before approving any fund request.
The JMF is a "sweep up fund", providing assistance **after** all other programs and assistance have
been exhausted.*

**Please see our website for helpful resources
www.jamestownmedicalfund.org**

Please send billing information with total amount of assistance requested to:

The Jamestown Medical Fund
PO Box 236
Jamestown, RI 02835