Dahl Memorial Clinic

Municipality of Skagway

GATEWAY TO THE KLONDIKE

P.O. BOX 537 SKAGWAY, ALASKA 99840

PHONE 907-983-2255 – Fax 907-983-2793

VERIFICATON OF ELIGIBILITY
CANCER FUND ASSISTANCE

Name of person requesting aid: _____

Address: _____

_____

Phone Number: _____

Reason for request (check all that apply)

_____ No health insurance and no other funding sources available (ie; BCHC or Medicaid)
_____ Request assistance with travel related expenses
_____ Patient has also applied for BCHC fund (Breast and Cervical Cancer Screening)

Name and address of service provider (Location of appointment and the dates you are going to be seen/receive treatment)

_____

_____

_____

Authorization to release limited medical information to justify treatment and expenses.

I authorize Dahl Memorial Clinic to validate the medical need for travel and treatment of my health condition. I understand that the Cancer Fund provides assistance for cancer related expenses only.

_____ _____

Signature of Patient Date

The above named individual qualifies by diagnosis for assistance with expenses related to a cancerous or pre-cancerous condition.

_____ _____

Health Care Provider Signature Date

Mail to: Virginia Long
PO Box 617
Skagway, AK 99840
983-2068