



## MEDICAL ASSISTANCE REQUEST FORM

### A APPLICANT INFORMATION

DATE \_\_\_\_\_

Full Name: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
\_\_\_\_\_

TRN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female      Marital Status:  Single  Married  Widowed  Other

Citizenship Status:  Jamaican Resident     Non-Resident     Returned Resident

Contact Number: (M) \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employment Status:  Employed  Self-Employed  Retired  Unemployed  Student

Current Occupation: \_ \_\_\_\_\_ Salary/Wage: \_ \_\_\_\_\_

Employer Name: \_\_\_\_\_

### B NEXT OF KIN INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

Contact Number: (M) \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_

Email Address: \_\_\_\_\_

### C MEDICAL INFORMATION

Diagnosis (as stated by physician): \_\_\_\_\_

**Brief Description of Illness/Condition:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Name of physician:** \_\_\_\_\_

**Name of Hospital/Health Facility:** \_\_\_\_\_

**Type of Assistance Required:** Surgery Medication Diagnostic Tests Dialysis  
Radiotherapy Orthopedic Device Eye Surgery  
Other (Specify)\_\_\_\_\_

**Have you ever received assistance from the Compassionate Fund?** Yes No

**Estimated Cost of Product/Service:** \$ \_\_\_\_\_

**Amount Being Requested:** \$ \_\_\_\_\_

**Proposed Date of Procedure/Treatment:** \_\_\_\_\_

**Urgency Level:** Emergency Urgent Elective

**D INSURANCE & OTHER ASSISTANCE**

**Do you have Health Insurance?** Yes No

**Name of Insurance Provider (if applicable):** \_\_\_\_\_

**Have you obtained a Pre-Authorization Letter?** Yes No

**Do you have a National Health Fund (NHF) Card?** Yes No

**Have you obtained NHF Pre-Authorization?** Yes No

**Have you sought or will you seek assistance from other sources?** Yes No

**Source(s) of Other Assistance:** \_\_\_\_\_

**Approximate Amount Expected from Other Sources:** \$ \_\_\_\_\_

**E DECLARATION**

I hereby declare that the information provided in this application is true and accurate to the best of my knowledge. I understand that providing false or misleading information may result in disqualification or recovery of funds disbursed.

\_\_\_\_\_  
**Applicant's Signature:**

\_\_\_\_\_  
**Date:**

<b>F</b>	<b>REQUIRED SUPPORTING DOCUMENTS</b>
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- Valid Government-Issued Identification
- TRN
- Medical Report/Letter (Signed & Stamped)
- Prescription (if applicable)
- Proforma Invoice/Quotation
- Pre-Authorization Letter (if insured)
- Birth Certificate (if minor)
- Job Letter (if employed)
- Character Reference (JP, Pastor, School Principal, Superintendent of Police or higher, Employer, MP/Counsellor, Social Worker)
  
- Written Letter of Request - Addressed as follows:
  - Principal Director
  - Enabling Environment in Health & Client Services Division
  - Ministry of Health & Wellness
  - 5 Sylvan Road, Kingston 5

<b>G</b>	<b>OFFICIAL USE ONLY</b>
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**Reference Number:** \_\_\_\_\_

**Received/Checked By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Interview Notes:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reviewed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**ASSESSMENT OUTCOME:**

- Approved     Approved + Referred to PS     Deferred     Not Supported

**Comments:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Approved Amount: \$** \_\_\_\_\_ **For PS' Approval: \$** \_\_\_\_\_

**Authorizing Officer:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

