



CUPHSONAA, INC.

THE COLUMBIA UNIVERSITY-PRESBYTERIAN HOSPITAL
SCHOOL OF NURSING ALUMNI ASSOCIATION, INC.

480 MAMARONECK AVENUE

HARRISON, NY 10528

TEL: (914) 481-5787

FAX: (914) 481-5788

SICK BENEFITS APPLICATION

ELIGIBILITY REQUIREMENTS: APPLICANTS MUST HAVE UNREIMBURSED COSTS RELATED TO SERIOUS ILLNESS OR INJURY AND DEMONSTRATE FINANCIAL NEED. ALL APPLICANTS FOR SICK BENEFITS MUST BE DUES-PAYING MEMBERS OF OUR ASSOCIATION FOR THE PAST 5 CONSECUTIVE YEARS. IF THE MEMBERSHIP REQUIREMENTS ARE NOT MET, THE APPLICANT IS REQUIRED TO PAY BACK DUES FOR THE PAST 5 YEARS AS LONG AS THE APPLICATION IS ACCEPTED AND THE BENEFIT IS TO BE AWARDED.

NAME:			
CLASS OF:			
ADDRESS:			
TELEPHONE(S):	(H)	(C)	(W)
E-MAIL:			
DUES PAID: SELECT ONE – YES <input type="checkbox"/> NO <input type="checkbox"/>			
I WOULD LIKE TO APPLY TO THE ALUMNI ASSOCIATION FOR ASSISTANCE WITH MEDICAL BILLS THAT HAVE RECENTLY ACCRUED.			
MARITAL STATUS:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER		
HISTORY OF ILLNESS:	PLEASE GIVE THE APPROXIMATE DATE OF ONSET, MEDICAL TREATMENTS, PRESCRIPTIONS REQUIRED.		

EMPLOYMENT STATUS:	
PRESENT EMPLOYER:	
STATUS:	<input type="checkbox"/> ACTIVE <input type="checkbox"/> PART-TIME <input type="checkbox"/> SEMI-RETIRED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED
INSURANCE COVERAGE: (CHECK ALL THAT APPLY)	
<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> DISABILITY <input type="checkbox"/> SECONDARY INS. <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> OTHER	
ANNUAL INCOME:	
SALARY / PER YEAR:	\$
PENSIONS / PER YEAR:	\$
SOCIAL SECURITY / PER YEAR:	\$
SOCIAL SECURITY DISABILITY INSURANCE – SSDI / PER YEAR:	\$
SUPPLEMENTAL SOCIAL SECURITY INCOME – SSI PER YEAR:	\$
PORTFOLIO INTEREST – PER YEAR:	\$
OTHER INCOME – PER YEAR: PLEASE SPECIFY	\$
NATURE OF REQUEST FOR ASSISTANCE: (PLEASE SPECIFY THE KIND AND AMOUNT REQUESTED)	
PRESCRIPTIONS:	\$
EQUIPMENT:	\$
PROVIDER BILLS:	\$
DIAGNOSTIC TESTS AND RADIOLOGY:	\$
HOSPITAL BILLS	\$
OTHER:	\$
TOTAL AMOUNT OF CLAIM THAT HAS BEEN SUBMITTED (WITH COPIES OF ALL RECEIPTS SHOWING BILLS AS PAID):	\$

CERTIFICATION STATEMENT OF APPLICANT

MY MEDICAL CLAIM(S) WAS/WERE COMPLETED ON:

MY MEDICAL CLAIM WAS COMPLETED BY:

I (AM) (AM NOT) RECEIVING ANY OTHER ASSISTANCE FOR THESE EXPENSES.

SIGNATURE:

CLASS:

DATE:

PHYSICIAN'S CERTIFICATE	
I CERTIFY THAT:	NAME:
LIVING AT:	ADDRESS:
HAS A DIAGNOSIS OF:	
AND THAT I AM INVOLVED WITH THE ONGOING TREATMENT.	
PHYSICIAN NAME:	
ADDRESS:	
DATE:	
LICENSE (STAMP)	

IF YOU HAVE ANY QUESTIONS PLEASE CONTACT US AT (914) 481-5787 OR BY EMAIL AT INFO@CUPHSONAA.ORG

YOU MAY FAX OR MAIL THIS APPLICATION. THANK YOU.

www.cuphsonaa.org