



Application for Assistance

Personal Contact Information

Name of Child _____

Child's Date of Birth _____

Parent or Guardian Name _____
(Please Print Clearly)

Mailing Address _____

Home Phone Number _____ E-Mail Address _____

Name of Person Preparing Form _____

Relationship to Child _____

Counselor/Physician Referral

Physician's Name _____

Hospital Affiliation _____

Physician/Counselor Contact Information _____
(Please include a phone number to be reached during business hours)

Date of Diagnosis _____

Diagnosis _____

Financial Information

- 1) Please provide a brief statement as to how your financial situation has changed since your child was diagnosed (excessive co-payments, prescriptions, loss of income etc.)

- 2) Have you received financial assistance from any other organization or agency?
Please provide the name of the organization, contact information, and amount of assistance.

- 3) Has money been raised on the patient's behalf? (e.g. friends, family, office, neighborhood fundraisers)

Emergency Needs Request

Indicate what type of financial assistance would most support the care of your child. Please attach supporting documentation (e.g. unpaid bills, premium notices)

Mortgage/Rent Payment	_____
Utility Bills	_____
Car Payment/Insurance	_____
Transportation Costs	_____
Lodging	_____
Health Insurance Premiums	_____
Prescriptions	_____
Child Care	_____
Other (Specify)	_____

Please note: The Fighting Children’s Cancer Foundation will not make any payments directly to a physician, hospital or medical care facility. Many of our referrals come through these entities, and we do not want any opportunity for conflicts of interest.

Future Correspondence

May we contact you to talk about your cancer experience, which might help raise funds for FCCF and increase awareness about pediatric cancer? _____

Please note, this is completely optional and will have no impact on your application for assistance.

All sections of the application must be completed. Consideration by the FCCF Financial Assistance Review Board can only be given to applications that are reviewed and signed by both a parent and/or guardian AND the child’s treating medical/health care professional.

Applications with original signatures should be mailed to:

FCCF
1700 Route 23 North
Suite 300
Wayne, NJ 07470

Should you have questions or need additional information, please contact FCCF at 908-429-2121 or send an email to: exdir@fccf.info.

I declare, to the best of my ability, that the information furnished on this application form is true and correct.

Name of Parent or Guardian (Please Print Clearly)

Signature of Parent or Guardian

Date

Name of Counselor/Physician

Signature of Counselor/Physician

Date