Application for Assistance

Personal Contact Information

First Name of Child_____ Last Name of Child_____

Child's Date of Birth_____ Child's Gender _____

Parent or Guardian Name_____
(Please Print Clearly)

Street Address:_____ Apartment: _____

City: _____ State: _____ Zip Code: _____

County: _____ Email address: _____

Home Phone: _____ Cell Phone: _____

Parent/Guardian Employer_____ Parent/Guardian Employer_____
_____ _____

Child's Race (Optional) Choose as many as is applicable:

____ White or Caucasian
____ Black or African American
____ American Indian or Alaska Native
____ Asian
____ Other (Please Specify) _____

Is the Child of Hispanic, Latino, or Spanish origin? (Optional)

____ No
____ Yes

Family Members in the home/ Family Composition _____
_____
_____
_____

Physician/Counselor Referral

Physician's/Counselor's Name _____

Hospital Affiliation _____

Physician/Counselor Mailing Address: _____

_____

Physician/Counselor Email Address _____

Diagnosis _____ Date of Diagnosis_____

Expected Duration of Treatment _____

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, neighborhood)

_____
_____

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 _____

Health Insurance Premiums _____

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.

Impact statement & Photograph (optional):

FCCF supporters often ask who they are helping and how their donations make a difference. In the space below, please share a few words about the impact that assistance from this organization would have on your family. Your statements will be shared with contributors to communicate the importance of raising funds to support children and families fighting this disease. **Also, if you are able, please attach a photograph with this application. Photos may also be emailed (as a jpeg or png attachment) to exdir@fccf.info Pictures will be shared with FCCF supporters in promotions including but not limited to: on-line media, print media, e-mail and mail correspondence, and video/photograph projection presentations.**

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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 may be faxed to 908.448.2502, emailed to exdir@fccf.info, or sent by hardcopy mail to:

FCCF
55 Lane Road, Suite 300
Fairfield, NJ 07004

Please contact us at 908-429-2121 or exdir@fccf.info if you need additional information.

By signing below, I consent to the Foundation's use of photographs, video, and impact statements for its marketing and fund-raising purposes. I declare, to the best of my ability, that the information on this FCCF application 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*