



## Application for Financial Assistance

*Supporting children and families affected by cancer—with hope, compassion, and heart.*

### SECTION 1: APPLICANT INFORMATION

Child/Children's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender (optional): \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

Home Address – Street: \_\_\_\_\_

City: State: ZIP: \_\_\_\_\_

### SECTION 2: MEDICAL INFORMATION

Name of Patient & Relationship to Child/Children:

\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Treating Hospital/Facility: \_\_\_\_\_

Oncologist or Social Worker Name & Contact Info:

\_\_\_\_\_

### SECTION 3: REQUEST DETAILS

Describe your situation and how this assistance will help:

\_\_\_\_\_

\_\_\_\_\_

Amount Requested (\$): \_\_\_\_\_

## SECTION 4: SUPPORTING DOCUMENTS

- Proof of diagnosis (doctor or hospital letter)
- Most recent medical bill or estimate
- Any other documents supporting your request

## SECTION 5: AUTHORIZATION & SIGNATURE

I certify that the information provided is true and complete to the best of my knowledge. I understand that this information will be used only to evaluate my application for assistance.

**Signature:** \_\_\_\_\_

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

### **Submit Application To:**

The Joseph S. Grippo Foundation  
835 West Shore Drive  
Kinnelon, NJ 07405

**Questions?** Contact Erica Grippo at 201-286-0060