



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