ZERO FACE FOUNDATION, INC.

Application for Financial Assistance

(To be completed by the patient's parent/legal guardian)

CHILD'S INFORMATION

Name: **DOB:** **Gender:**

Street Address:

City: **State:** **Zip:**

MEDICAL INFORMATION

Child's Diagnosis:

Date of Diagnosis:

Treating Clinic/Hospital Name:

Oncologist's Name:

Phone Number: **Email Address:**

Social Worker's Name (if applicable):

Phone Number: **Email Address:**

Please describe the child's condition, treatment and other pertinent information:

PARENT/LEGAL GUARDIAN INFORMATION

Name of Parent(s)/Legal Guardian(s):

Street Address:

City: **State:** **Zip:**

Phone Number: **Email Address:**

HOUSEHOLD INFORMATION

Number of people in household (including child):

Number of children (under 18) in household:

Housing situation: ◯ Stable ◯ Unstable ◯ Prefer not to answer

Net Monthly Household Income (after taxes) Please include all sources of income including government assistance, family assistance, child support, alimony:

Intended use of grant:

RELEASES

☐ I authorize Zero Face Foundation, Inc. to share my child's story in promotional materials and on social media.
**Authorizing Zero Face Foundation, Inc. to share your child's story is not a requirement for financial assistance.*

☐ ***I declare that the information provided on this application is true and correct to the best of my knowledge. I understand that each application is reviewed on a case-by-case basis, and the final decision will be made by Zero Face Foundation, Inc.***

☐ ***I hereby authorize my child's medical team and social worker to provide medical information regarding my child as it relates to this application with Zero Face Foundation, Inc.***

_____ Date: _____
Parent/Legal Guardian's Handwritten Signature

Clear Application

Save Application

Print Application