love, chloe FOUNDATION
A CHILDHOOD CANCER ORGANIZATION

Instructions to Financial Assistance Application

To apply for financial assistance from the Love, Chloe Foundation, please complete and submit the attached application along with the required accompanying documents. Subject to the availability of funds for grant, applications are reviewed by our Family Support Council approximately once a month. You will be contacted by the Love, Chloe Foundation following review of your application.

1. Any family with a child diagnosed with cancer prior to the child's 18th birthday is eligible for consideration.

2. Due to limited funds, families must be a resident of the state of Kansas to be considered for assistance.

3. The applicant must be the parent or legal guardian of the diagnosed child and the primary caregiver of the child. A photocopy of the child's birth certificate or other evidence of parental or guardian status must be submitted with the application. Applicants must be U.S. residents.

4. The application must be accompanied by a signed letter from the child's treating physician on the physician's letterhead stating the child's full name, date of birth and diagnosis.

5. All sections of the application must be completed, and all accompanying documents must be submitted in order for our Family Support Council to review the request. Failure to provide complete information is a basis for denial of an application.

6. Assistance may be requested one time during any 12-month period. Each request for assistance requires submission of a new application.

7. Please contact Heidi Feyerherm-Smith at (785) 342-5534 or heidi@lovechloe.org if you have any questions concerning the application process.

After you complete the application, please send it and the required accompanying documents by mail or e-mail to:

Love, Chloe Foundation
116 S Santa Fe
Salina, KS 67401
heidi@lovechloe.org

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Financial Assistance Application

Parent/Guardian's Name (first, middle, last):_____
Street: _____
City:_____State:_____Zip Code:_____
Home Phone:_____Daytime Phone:_____
Email address:_____

Child's Name (first, middle, last): _____
Date of Birth:_____ Social Security #:_____
Type of Cancer Diagnosed: _____
Date of Diagnosis:_____
Medical Institution where Diagnosed/Treated:_____
Name of Treating Physician: _____
Phone # and Email Address of Physician: _____

Please complete the following:

☐ I confirm that I am my child's primary caregiver and that as a result of a severe economic hardship due to my child's cancer, my family has suffered a short-term emergency need for assistance with basic necessities such as food, clothing, housing, transportation and medical assistance.

☐ Financial assistance from the Love, Chloe Foundation would help provide needed support in order for my family to have basic necessities such as food, clothing, housing, transportation and medical aid and I request emergency assistance in the amount of $_____ (up to $1,500), which will be used as follows: _____
_____
_____
_____
_____
_____.

I ☐**grant** ☐**do not grant** (*Please check one*) permission for the Love, Chloe Foundation and its representatives to use photographs, audio recordings, letters, survey information or video recordings of my child or myself, our names and my child's story to inform families, volunteers, the media and the general public about the Love, Chloe Foundation and its programs, services and events. Such materials may be used in, among other items, promotional materials, newsletters or on the foundation's web site. If permission is granted above, I, for myself and my child, release

all claims against the Love, Chloe Foundation and its representatives with respect to copyright ownership and publication, including any claim for compensation related to use of these materials.

I heard about the Love, Chloe Foundation through the following:

- ☐ Family
- ☐ A parent of a child with cancer
- ☐ Physician
- ☐ Social Worker
- ☐ Other:_____

By signing below:

- I authorize the Love, Chloe Foundation and its agents and representatives to contact the above-named medical institution and physician in order to verify my child's cancer diagnosis.

- I authorize the above-named medical institution and physician to release to the Love, Chloe Foundation and its agents and representatives any information and medical records deemed necessary by the Love, Chloe Foundation to complete its verification of my child's cancer diagnosis.

- I attest that the information provided above and accompanying this application is true and correct to the best of my knowledge. I acknowledge that the Love, Chloe Foundation will pursue and is entitled to restitution for a grant if it is determined that the information submitted on this application is false.

_____ _____

Signature of Parent/Guardian **Date**

All applications will be reviewed on a case-by-case basis and a final determination will be made based upon other applications submitted to the Love, Chloe Foundation and the availability of funds. You will not be discriminated against based on race, religion, color, national origin, sex or political affiliation.

For the Love, Chloe Foundation use only:

Date received: _____ Date Reviewed: _____ Approval Status: _____