Personal Information

Child's Legal Name: _____

DOB (MM/DD/YYYY): _____ **Gender:** _____

Parent/Guardian Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____

E-mail Address: _____

Annual Household Income: _____
*(please include **all** sources of income)*

Requested Grant Amount: _____
(dollar amount required)

Intended Use of Grant: *If applicable, please provide bills paid directly to the vendor with the vendor name, account number, mailing address, family's last name and the dollar amount owed.*

_____

_____

_____

Parent/Legal Guardian's Signature: _____

Date: _____

By signing this application, you are agreeing to allow publication of your child's name, medical condition and/or likeness by The Lilly Lights the Way Childhood Cancer Foundation. Additionally, by signing this, you are giving your medical professionals and LLTW permission to share medical information about your child's case. Finally, by signing this, you are consenting to allow LLTW to share your application with other organizations in an effort to potentially gain additional funds for you.

Medical Information

Child's Diagnosis: _____

Date of Diagnosis: _____

Child's Physician: _____

Hospital: _____

Hospital Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Worker's Name and Title: _____

Social Worker's Direct Phone and Extension: _____

Social Worker's E-mail Address: _____

Please describe the child's medical condition, anticipated hospital stay, and any other notable facts
(please attach a separate document if you need more room to write)

_____

_____

_____

_____

Social Worker's Hand Written Signature: _____

Date: _____

By signing this application, you are attesting to the accuracy of the information on both pages, to the best of your knowledge. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.