Mission: Enhancing the lives of families of children with cancer by providing education and advocacy, emotional and practical support, and most of all…..HOPE

Application for Financial Assistance

Please email the completed application to: DC Candlelighters Childhood Cancer Foundation at dccandlelighters@gmail.com

Please note: Financial assistance is limited to $500 per family, per calendar year provided funding is available.

Application Date _____

Treatment Facility:

- Children's National Medical Center
- Georgetown University Hospital
- Inova Fairfax Hospital
- National Institutes of Health
- Walter Reed National Military Medical Center

Patient Name (first, middle initial, last)

_____

Gender:

- Male
- Female

Date of Birth _____
Diagnosis_____

Date of Diagnosis _____

Parent/Guardian Name (first, middle initial, last)

_____

Permanent Address

_____

_____

Phone (___)_____ email _____

Child's address (if different from parent)

_____

_____

Mother/Guardian's Employer _____

Address and phone number _____

_____

Father/Guardian's Employer _____

Address and phone number _____

_____

May we contact you at work? Yes _____ No _____

Reason for request:

- Basic living expenses such as rent/mortgage, utilities, car repairs, etc.
- Travel costs related to treatment and doctor visits
- Medical/Pharmacy expenses
- Funeral expenses
- Other (please describe below)

_____

_____

Amount requested $ _____

Please attach a copy of bills for which you are requesting payment.

Consent to Release Information:
I authorize the staff at _____ to release to DC Candlelighters Childhood Cancer Foundation any information regarding my child's cancer treatment and related expenses necessary to verify my application for financial assistance.

Parent Signature _____ Date _____

Doctor/Social Worker Signature _____ Date_____

Please email completed application, including receipts, to:
dccandlelighters@gmail.com