



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 (Check is usually made payable to the funeral home.)
- Other (please describe below) Please include the Date of Death _____

Amount requested \$ _____

Applications cannot be processed without a copy or photo(s) 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 with substantiating photos or receipts, to:

dccandlelighters@gmail.com