THEY CAN'T WIN THE FIGHT WITHOUT YOU

20480 Via Zaragoza, Yorba Linda CA 92887
Phone: (949) 371-4840
Web Address: www.KidsCancerFund.org (CONFIDENTIAL)

APPLICATION FOR FINANCIAL ASSISTANCE GRANT
(PLEASE PRINT ALL INFORMATION CLEARLY)

Child's Name: ____

Age:_________ Date of Birth: ___________

Address: ____

City: ______________________________ State: ______________ Zip Code: ___________

Home Phone:_____________________________Cell Phone: ____________________________

E-Mail: ____

Type of Cancer: ____

Please describe how the grant will be used and amount requested: ________________________
____
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Notes:

1. Eligibility ends at age 18.
2. Amount of grant awarded depends on the number of applications received, applicant's need and amount of funds available for disbursement.
3. Parent/Guardian gives permission for child (first name only) to be mentioned as grant recipient on Kids Cancer Fund website and announcements.
4. Parent/Guardian agrees to submit a photo of child and gives permission that photo may be featured on Kids Cancer Fund website and announcements.

Name of Parent/Guardian: ____

Signature of Parent/Guardian: ____

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APPLICATION FOR FINANCIAL ASSISTANCE GRANT
DIAGNOSIS VERIFICATION FORM
(MUST BE SIGNED BY PHYSICIAN)

Child's Name: ____

Age:_________ Date of Birth: ____________

Verification of Cancer as a diagnosis:___________Yes___________No

Name of Physician: ________________________________

Physician Signature: _______________________________

Doctor Office/Clinic: ____

Doctor Office/Clinic stamp (required): ____

Phone: ________________________________

Date: _________________

Additional Comments

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____