KIDS CANCER FUND

1950 Minarets LN, Clovis CA 93611
Phone: (949) 562-1080
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: _____

_____

_____

_____

_____

_____

_____

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?:

_____
_____
_____
_____