
*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 $ _____

**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