



Application for Financial Assistance

Please fill out the following form and submit
via email to apply@americanfoundationcc.org, or via postal mail.

Patient Name:

Birth date (M/D/Y):

Parent/s or Guardian Name:

Telephone Number

Parent or Guardian Address:

City

State

Zip

Are you currently employed?

If so, where? _____

What type of Cancer does the Child have and what treatment are they undergoing?

What bills are you seeking assistance for and how much? Please be Specific:

*AFCC may require a copy of the bills which financial assistance is being requested for.

Are you currently receiving aid or assistance from any other charity?

And if so, how much and from whom?

As part of our ongoing efforts The American Foundation for Children with Cancer requires a photo of the child. Do you agree to have you and your child's picture taken?

Also, we may also use your child's story on our website and or press release. AFCC does this to elicit further funds and to show our efforts and charity in the community. Do you agree to AFCC using your child's story?

In order to receive assistance you must agree to the aforementioned, if not we may not be able to provide all the support requested. I understand The American Foundation for Children with Cancer (AFCC) may verify the financial information contained in this Financial Assistance Application ("Application"). I certify that the statements made in this Application are true and correct, to the best of my knowledge and belief, and are made in good faith. I am aware that falsification or misrepresentation of information on this Application may result in denial of financial assistance.

Signature of parent

Print Name

AFCC Employee Signature if any part of Financial Assistance Application Completed by an AFCC Employee

Print Name

For Hospital Use only:

Verification:

Name of Person Contacted: _____

Date: _____

Name of Institution or Hospital:

Information obtained:

Name of Person Contacted Signature _____

Date: _____

Do you feel this person is under sufficient financial distress to receive the funds requested? _____

Additional Notes regarding patient:

If responsible party is unable to sign the application, state why:

AFCC Use Only:

Approval Status: _____

Amount Being Awarded _____

AFCC Employee Signature _____

Date: _____

Other notes:
