Candlelighters
childhood cancer support programs

Application Form for Financial Assistance

Date of Application: ____________________ **Requested By:** __________________________________

Patient/Parent's Name: ____

○ **On Treatment** ○ **Off Treatment** ○ **Palliative**

Date Eligible to Qualify for Benefits: ____

Anticipated Return to Work Date: ____

Financial Assessment Completed: ______________________ **By Whom:** ________________________

Name of Other Organizations Contacted or Providing Assistance: (POFAP, CCS, NOFCC etc.)

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Additional Information: ____

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Type of Assistance Requested: ____

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Amount Requested: ___________________

Payable to: ____

Address:____

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Office Use

Amount Approved: ________________ Approved By: _________________________________

Date: _________________ Data Entered: _________ Budget Line: ___________

Updated March 2019
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