

...because kids can't fight cancer alone!



Application for Financial Assistance

Please complete the application and mail to: Candlelighters of the DC Area, C/O Tasha Virostek, 13443 Marble Rock Drive, Chantilly, VA 20151.

Please note: financial assistance is limited to \$500 per family provided that funding is available.

Application Date _____

Treatment Facility:

- Children's National Medical Center
- Georgetown University Hospital
- Inova Fairfax Hospital
- Walter Reed Army Medical Center

Other _____

_____ Male Female

Patient Name (first, middle initial, last)

Date of Birth _____ Diagnosis _____

Date of Diagnosis _____

Parent/Guardian Name

Permanent Address _____

Phone () _____ email _____

Child's address (if different from parent) _____

Address and phone number _____

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
- Pharmacy expenses
- Funeral expenses
- Other (explain below)

Amount requested \$ _____

Please attach a copy of any bills for which you are requesting payment

Consent to Release Information:

I do hereby authorize the staff at my child's treatment center to release to Candlelighters of the DC Metro Area any information pertinent to cancer treatment and related expenses deemed necessary to complete Candlelighters' investigation of my application for financial assistance.

Parent Signature _____ Date _____

Doctor/Social Worker Signature _____ Date _____

Please mail complete application to:

Candlelighters of the DC Metro Area
C/O Tasha Virostek
13443 Marble Rock Drive
Chantilly, VA 20151
dccandlelighters@gmail.com