Date ____________________

Your Name ____

Address ____

____

Telephone # ____

Relationship to patient ____________________

Are you the primary caregiver? (circle one) Yes or No

Does your child live with you? (circle one) Yes or No

Marital Status: (circle one) Married Single

Number of children living with you____________

Names and ages:

____

____

____

____

Number of adults living with you other than a spouse ______________________________

State name, type and place of employment if working __________________________

____

____

____

____

INFORMATION REGARDING YOUR CHILD

Name of child ____

Date of birth ______________________ Age______________________

Sex of child: (circle one) Male or Female

Diagnosis____
____
____

Date of Diagnosis________________

Where does your child receive treatment? ______________________
____
____

Is your child actively in treatment? If yes, please list type of treatment ____________
____

What is the last day your child had treatment and where ______________
____

How often does your child have this treatment? ______________________

Primary care physician's name, address and telephone ______________
____
____

PLEASE ATTACH A LETTER FROM THE CHILD'S TREATING PHYSICIAN STATING THEIR DIAGNOSIS AND TREATMENT PLAN.

Financial Request Information

Amount Requested ________________

Date Needed ________________

Please explain in detail how this money will be spent. ______________
____

IF THIS REQUEST IS FOR A BILL, PLEASE ATTACH A COPY TO THIS APPLICATION

Please explain in detail the reason for your request and how your child's illness has affected this financial need:

Have you sought funds elsewhere? If so, where?

Are you currently receiving funds from other sources or agencies? If so, where, amount and frequency.

Are you presently receiving any income from sources other than your job? If so, explain.

Employment Information

Do you work? _______ If not, please specify why and when you stopped working:

Employer's Name, Address and Phone #

Does your spouse work? (If applicable) ____________

If not, please specify why and when they stopped working:

Spouse's Employer Name, Address and Phone #

Please add any other information that you think might be relevant in our decision making.

Applicant's Signature

Date

*Signature of this application gives the Childhood Cancer Awareness Group of Coffee County permission to contact any employers, suppliers, etc.

Upon completion of application, please contact any of the following officers and they will get your application processed.

Barbara Dockery	(912) 381-3122
Karen Medders	(912) 381-6903
Julie Harper	(912) 384-2287
Shelia Butler	(912) 389-2345

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Approved ________________ Date ____________________

Approved by/signature ____________________________

Amount approved ________________________________

Monies Paid to: ______________________________________

Childhood Cancer Awareness Group
of Coffee County

TOGETHER WE CAN

PO Box 1203
Douglas, Ga 31534

PHYSICIAN TREATMENT PLAN

PATIENT'S NAME ____

DIAGNOSIS: ____

IS THIS CANCER? ____

CURRENT TREATMENT PLAN: _____________________________________

____

*ANTICIPATED FREQUENCY/LENGTH OF TREATMENTS:

START DATE: _________________ END DATE: _______________

PHYSICIAN'S NAME: ____

PHYSICIAN'S SIGNATURE: ____DATE: __________________

PHYSICIAN'S ADDRESS: ____

____

PHYSICIAN'S TELEPHONE: ____

*We realize this treatment could change based on patient's condition. An updated plan will be required if treatment is stopped and restarted.

This information is strictly confidential and is the guardian's responsibility to obtain the information from the patient's physician.

Thank you for assisting this family in completing this form. This information is used to determine if the patient is eligible to receive financial assistance from our organization. We are a non-profit group providing financial and emotional support to families of children with childhood cancer.