One of the objectives of The Andrew McDonough B+ (Be Positive) Foundation is to financially assist deserving families of kids battling cancer. The Foundation provides grants to minimize the financial hardship that is ***directly attributable*** to the child's illness.

APPLICATION FOR FINANCIAL ASSISTANCE

(To be completed by child's parent/legal guardian – You can type directly in to this document. If you submit a completely hand-written application, **PLEASE PRINT**)

Child's Name: _____ **Age:** _____ **Gender:** _____

(Information will be used for statistical purposes only and will not affect eligibility)

Ethnicity: African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐

Native American ☐ Other: _____ Prefer not to answer: ☐

Parent/Legal Guardian Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Cell Phone:** _____

Email Address: _____

ANNUAL Household Income ***(i.e. government assistance, child support, alimony, family assistance, all sources of income to pay living expenses)*:** _____

Requested Grant Amount ($ amount required): _____

Intended use of grant ***(Please provide bills paid directly to the vendor with the vendor name, account number, mailing address, family's last name and dollar amount)*:** _____

_____

_____

_____ _____

***Parent/Legal Guardian's Hand-Written Signature** **Date**

** By signing this application, you are agreeing to allow publication of your child's name and medical condition by The Andrew McDonough B+ Foundation. Additionally, by signing this, you are giving your medical professionals and The B+ Foundation permission to share medical information about your child's case. Finally, by signing this, you are consenting to allow The B+ Foundation to share your application with other organizations in an effort to, potentially, gain additional funds for you.*

MEDICAL INFORMATION

(To be completed by a social worker. You can type directly in to this document. If you submit a completely hand-written application, **PLEASE PRINT**)

Child's name: _____

Child's diagnosis: _____

Date of Diagnosis (Month-Day-Year): _____

Child's Physician: _____

Hospital: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Worker's Direct Phone Number and Extension: _____

Please describe the child's medical condition, anticipated hospital stay, and any other notable facts ***(please attach letter if needed)*****:** _____

_____

_____

_____

_____

_____

_____

Has this family previously received assistance from The Change Reaction (Clark/Perlmans): _____

Social Worker Name and Title (please print): _____

***Social Worker's Hand-Written Signature:** _____

Date: _____ **Social Worker's Email Address (please print):** _____

** By signing this application, you are attesting to the accuracy of the information on both pages, to the best of your knowledge. Fraudulent applications may result in your institution being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.*