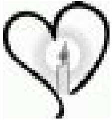

Candlelighters of Central Arkansas

Application for Financial Assistance

Please complete application and mail to: Candlelighters of Central Arkansas, 1805 Dorado Beach Dr., Little Rock, AR 72212. A volunteer will contact you if your family has been selected. We cannot guarantee that all applicants will be selected. Please apply only if you have not been selected to receive similar services by another organization.

Application Date____________________

Patient's Name (first, middle initial, last)____________________________________ Male___Female___

Date of Birth_________________ Diagnosis____

Parent/Guardian Name____

Permanent Address____

Phone (   )____ E-mail______________________________

Child's address (if different from parent)____

Father/Guardian's Employer____

Address and Phone Number____

Mother/Guardian's Employer ____

Address and Phone Number____

May we contact you at work? Yes______ No______

Please provide names and ages of child's siblings:

____ Age___________

____ Age___________

____ Age___________

____ Age___________

____ Age___________

____ Age___________

Has your family received financial help from another organization? If so, explain.

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Reason for Request:

- ❑ Basic living expenses such as rent/mortgage, utilities, car repairs, etc.
- ❑ Travel costs related to treatment and doctor visits
- ❑ Food and lodging related to treatment and doctor visits
- ❑ Long-distance expenses related to treatment
- ❑ Pharmacy expenses
- ❑ Funeral expenses
- ❑ Other

Amount requested $___________________

Please use this space to explain why you are making this request

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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 Central Arkansas 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 completed application to:

Candlelighters of Central Arkansas
P.O. Box 3854
Little Rock, AR 72212