



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 the 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 Legal Name: _____ DOB: _____ 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 (Full Name): _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail 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 – **required** (*if applicable, please provide bills paid directly to the vendor with the vendor name, account number, mailing address, family's last name, and dollar amount owed*): _____

*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 Diagnosis: _____

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

Child's Physician: _____

Hospital: _____

Hospital Address: _____

City (Full Name): _____ 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 a letter if needed):

Social Worker's 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.

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