A Mother's Kiss
P.O. BOX 513, RIDGE, NY 11961
631-924-2770
Fax: 631-924-0771

_____ is a _____ year old boy / girl diagnosed with _____ (date of diagnosis _____, age at diagnosis _____) currently under the care of Dr._____. He / She is currently receiving cancer treatment or hospice care at _____.

☐ Active Treatment

As a result of this child's illness, the family has encountered difficulties in meeting their expenses and is seeking assistance for the following bills:

1. _____
2. _____
3. _____

Attach copies of bills or receipts to request form. Names on bills must match information below*.

Please use the following space to include any extenuating circumstances that you feel may be relevant to the family's request: (Current financial status, family situation, etc.)

_____

_____

_____

If the family has sought financial assistance from other childhood cancer organizations, please check here:_____. Organization Name: _____

In many cases, it will be necessary to contact the family directly. Please provide the parents name, address, and phone number with this request. It is **EXTREMELY IMPORTANT** that the name of at least one parent be included in this request. **Please complete forms neatly and legibly to avoid delay or denial.**

X_____
Parent or Guardian Signature

X_____
Social Worker Signature

X_____
Parent or Guardian Name Printed

X_____
Social Worker Printed

_____
Parent or Guardian Home Phone #

_____
Social Worker Phone #

_____
Parent or Guardian Alt. Phone #

_____
Social Worker Fax #

Home Address (must be domiciled in the counties of Nassau or Suffolk):

_____

*Mailing address (if different) or Additional Parent or Guardian Contact Info:

_____

FORM MUST BE COMPLETED IN ITS ENTIRETY TO BE CONSIDERED FOR ASSISTANCE.

Please fax completed form to 631-924-0771.