Adam's Angels Ministry
Financial Assistance Application

PARENT/LEGAL GUARDIAN INFORMATION

Mother's Full Name:		
Home Phone No.:	Cell Phone No.:	
Father's Full Name:		
Home Phone No.:	Cell Phone No.:	
Legal Guardian's Name: (if different than the above)	**Relationship:**	
Home Phone No.:	Cell Phone No.:	
Mailing Address:		
City:	State:	Zip Code:
Marital Status: ☐ Single ☐ Married ☐ Divorced	Are mother & father living at same address: ☐ Yes ☐ No	
Current address (where patient resides):		
City:	State:	ZIP Code:
Status of Home: ☐ Own ☐ Rent ☐ Live w/relative	If own or rent how long at this address?	Monthly mortgage or rent payment: $
Mother's Employer: (if applicable)		
Employer's Telephone No.:		
Father's Employer (if applicable):		
Employer's Telephone No.:		
Legal Guardian's Employer (if applicable)		
Employer's Telephone No.:		
Primary Email address (if applicable):		
Alternate Email address:		
Are you presently attending a church? ☐ Yes ☐ No	Are you a member? ☐ Yes ☐ No	
If yes, Name of Church:		
Address:		
Do you have a CarePage or CaringBridge Site or Facebook page? ☐ Yes ☐ No	If yes, page address or Facebook page title:	
May we add your child's name to our church prayer list & AAM Facebook page? ☐ Yes ☐ No		

BENEFITS PRESENTLY RECEIVING

Receiving Child Support: ☐ Yes ☐ No	Amount per month:
Receiving Food Stamps: ☐ Yes ☐ No	Amount per month:
Receiving SSI Benefits: ☐ Yes ☐ No	Amount per month:
Please list any other assistance from other organizations being received below:	

PATIENT INFORMATION

Patient's Full Name:

Type of Cancer:		**Age:**
☐ **Male** ☐ **Female**	**Date Diagnosed:**	**Date of Birth:**

Patient Treated At: ☐ Texas Children's Hospital-Houston, TX
☐ Children's Cancer Hospital of MD Anderson-Houston, TX ☐ Dell Children's Hospital-Austin, TX

Patient is presently: ☐ In Treatment ☐ Relapsed ☐ In Remission ☐ Deceased
☐ In Maintenance – time remaining in maintenance _____

Name of your hospital social worker (required):

Telephone No.:

Are you signed up with Candlelighters? ☐ Yes ☐ No

If Yes, Name of Parent Consultant w/Candlelighters:

Additional patient information:

Patient's favorite color and interests:

OTHER FAMILY MEMBERS LIVING WITH YOU

Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		
Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		
Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		
Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		
Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		
Name:		
Age:	☐ Male ☐ Female	Date of Birth:
Relationship:		

ASSISTANCE REQUESTED

Parking Token: ☐ Yes ☐ No	**Fuel:** ☐ Yes ☐ No	**Rent:** ☐ Yes ☐ No
Utilities: ☐ Yes ☐ No	**Water Bill:** ☐ Yes ☐ No	**Telephone:** ☐ Yes ☐ No

IF YOU ARE REQUESTING ASSISTANCE WITH RENT, UTILITIES, WATER OR TELEPHONE YOU MUST ATTACH A COPY OF THE MOST RECENT BILL. WITHOUT THESE COPIES APPLICATIONS WILL NOT BE CONSIDERED. ALL PAYMENTS ARE MADE DIRECTLY TO THE BILLING COMPANY AND NOT TO THE APPLICANT.

Other specific bills you would like considered not mentioned above: ☐ Yes ☐ No

If yes, please explain and remember to attach a copy:

Any other information you would like to share:

All Information is this application is confidential and will only be viewed or shared by AAM Board Members. By signing this application you are granting permission to AAM to verify with the parties mentioned on this form information that you have provided.

Signature of Parent/Guardian:	Date:
Signature of Parent/Guardian:	Date:

APPROVAL OF SOCIAL WORKER

Signature: ***Date:***

Printed Name:

APPLICATIONS MUST BE SUBMITTED WITH THE APPROVAL OF YOUR SOCIAL WORKER IN ORDER TO BE CONSIDERED.
DID YOU DOWNLOAD OR ATTACH A COPY OF THE BILL?
YOU MAY ALSO MAIL OR SEND BY EMAIL. WE DO NOT RECEIVE FAXES!

Revised 01-01-2017