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.*	
Family's Primary Mailing Address:		
City	*State*	*Zip*
Does patient reside at above address? ☐*Yes* ☐*No*	***If no, provide address:***	
Legal Guardian's Name: *(if not parents)*		***Relationship:***
Home Phone No.	*Cell Phone No.*	
Mailing Address		
City	*State*	*Zip*
Marital Status: ☐*Single* ☐*Married* ☐*Divorced*	***Are mother & father living at same address?*** ☐*Yes* ☐*No*	
Status of Home: ☐*Own* ☐*Rent* ☐*Live w/relative*	*How long at this address?*	*Monthly 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.:		
Family's Primary Email address: *(if applicable):*		
Secondary Email address:		
Are you presently attending a church? ☐ *Yes* ☐*No*	*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*		

Financial Assistance Application

Benefits Presently Receiving

Child Support: ☐Yes ☐No	Amount per month:
Food Stamps: ☐Yes ☐No	Amount per month:
SSI Benefits: ☐Yes ☐No	Amount per month:
Housing: ☐Yes ☐No	Amount per month:
Other assistance received:	

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 ☐TCH- The Woodlands TX ☐TCH – Katy TX ☐ Dell Children's Medical Center-Austin TX ☐MD Anderson Children's Cancer Hospital -Houston, TX

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

Name of hospital social worker (required):

Telephone No.:

Signed up with Candlelighters? ☐Yes ☐No	Consultant's Name:

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:

AdamsAngelsMinistry.org • angels@AdamsAngelsMinistry.org • P O Box 2573 • Brenham, Texas 77834-2573 • 979-836-0955

Financial Assistance Application

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: ☐Yes ☐No	**Fuel:** ☐Yes ☐No	**Telephone:** ☐Yes ☐No	**Water:** ☐Yes ☐No
Utilities: Gas ☐Yes ☐No Electric ☐Yes ☐No	**Car:** ☐Yes ☐No	**Rent: (no partial payments)** ☐Yes ☐ No	**Groceries:** ☐Yes ☐No

Other:

***MUST* ATTACH A COPY OF THE MOST RECENT BILL. WITHOUT COPIES APPLICATIONS WILL NOT BE CONSIDERED. ALL PAYMENTS ARE MADE DIRECTLY TO THE PROVIDER, NOT TO THE APPLICANT.**

Any other information you would like to share:

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

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

APPROVAL OF SOCIAL WORKER

Signature: **Date:**

Printed Name:

DID YOU DOWNLOAD OR ATTACH A COPY OF THE BILL REQUESTING PAYMENT ON?
DID YOUR SOCIAL WORKER SIGN THE ABOVE APPROVAL?
DID YOU ANSWER ALL THE QUESTIONS?

APPLICATIONS MAY BE EMAILED OR MAILED BY YOUR SOCIAL WORKER.
WE DO NOT RECEIVE FAXES!

Revised 01-01-2019