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www.voicesagainstcancer.org
EIN: 84-3628615

Family Request for Assistance from Voices Against Cancer
Patient/Family Information

Requirements:

- Child must be currently diagnosed with cancer or relapsed in the last 12 months.
- Child must be 18 years or younger.
- Child must be living with parents/guardians in the South Dakota, North Dakota, Minnesota, Iowa, or Nebraska region at time of diagnosis.
- Pediatric Physician, Hematologist, and/or Oncologist signature is required.

At the current time, Voices Against Cancer can only provide gift cards for gas, groceries, and lodging. Please be advised that we will make every effort to assist you, however submitting an application does not guarantee funds will be available to assist you.

Please print neatly.

Patient Name: _____ D.O.B. _____
Parent/Guardian Name: _____
Parent/Guardian Name: _____
Current Address: _____
Street City State Zip
Best Phone Number: _____
Email: _____
Receiving Treatment at: _____
(Location of treatment has no effect on determination of assistance)
Please rank from greatest need to least need your preference for assistance (gas, groceries, lodging)

1. _____
2. _____
3. _____

Have you applied for, or received financial assistance, from Voices Against Cancer before? _____
If yes, when? _____

I certify that to the best of my knowledge the information listed above is accurate and complete. I hereby give permission for applicant's personal and medical information to be shared with Voices Against Cancer pursuant to this request only for financial and referral assistance.

Printed Name: _____
Signature: _____ Date: _____
Relationship to Patient: _____