



HAWAII CHILDREN'S CANCER FOUNDATION

1814 Liliha Street • Honolulu, Hawaii 96817

Direct Line: 528-5161 • Fax: 521-4689

Toll-Free: 1-866-443-HCCF (4223)

www.hccf.org

FAMILY ASSISTANCE APPLICATION

Patient's Name: _____ Patient's Birthdate: ____ / ____ / ____

Parent's Names: _____

Address: _____

Phone: _____ Business: _____ Cell: _____

Email Address: _____

Patient's Oncologist: _____

Date of Diagnosis: _____ Patient's Diagnosis: _____

Signed by physician, social worker or healthcare provider verifying diagnosis:

(Signature)

Hawaii Children's Cancer Foundation (HCCF) has limited funds for patient assistance. HCCF may grant up to **\$4,000** per family during the first year of treatment; and up to **\$2,000** per family for the subsequent years of treatment. We will fund only expenses not covered by your health insurance or other assistance programs.

Please indicate the type and amount of assistance you are requesting.

- () Payment of treatment bills: \$ _____
- () Travel to treatment: \$ _____
- () Medical supplies: \$ _____
- () Prescriptions/medications \$ _____
- () Other – Specify item(s) \$ _____

A copy of the bill must be attached, for which you are requesting assistance or reimbursement. Please also indicate the details (such as specific supplies, cost, amount needed, and supplier).

Explain: _____

Authorization to Release Information

I hereby authorize HCCF and its representatives or agents to contact my child's physician, medical institution or facility, medical insurance company or the provider of services for the bill(s) for which I am seeking reimbursement or payment in order to verify the charges incurred and to verify whether the charges are related to my child's cancer diagnosis.

I also hereby authorize

_____ (name(s) of physician, institution or provider) to release information and records to HCCF and its representatives or agents with regard to my child _____ as HCCF may request of said physician, institution or provider.

Signed: _____

Print Name: _____

Relationship to child: _____

Date: _____

Witness:

Signed: _____

Print name of witness:

For HCCF use only:

Date received: _____ Date approved: _____ Application # _____

Please call 528-5161 if you have further questions. Mail this form to:

Hawaii Children's Cancer Foundation
1814 Liliha Street
Honolulu, Hawaii 96817

How did you hear about HCCF?

- Other parents/family
- Physician
- Nursing Staff
- Newsletter
- Other: _____

I am interested in the following:

- Financial/Travel Assistance
- Parent to Parent Support
- Children's/Siblings Groups
- Getting support/special help for child to succeed in school.
- Candlelighters (national childhood cancer organization)
- Information on child's diagnosis.
- Long-term care.
- Other: _____

You will automatically be enrolled as a member (there is no fee)
and added to our mailing list for all HCCF activities.

Signature _____ Date: _____

**TO REQUEST SERVICES OR INFORMATION,
Please call 528-5161
Or
Toll free: 1-866-443-HCCF (4223)**

**Please mail this form to:
HAWAII CHILDREN'S CANCER FOUNDATION
1814 Liliha Street
Honolulu, Hawaii 96817
ATTN: Membership Committee**