

530 Montour Blvd, Suite B
Bloomsburg, PA 17815



(570) 437-0341
www.thinkbigpa.org

APPLICATION FOR FINANCIAL ASSISTANCE

CHILD'S NAME: _____ DOB: _____

PARENT/LEGAL GUARDIAN NAMES: _____

ADDRESS: _____

CITY: _____ COUNTY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

ANNUAL HOUSEHOLD INCOME: _____ FAMILY SIZE (INCLUDING PATIENT): _____

SUMMARY OF CHILD'S DIAGNOSIS (INCLUDING DATE OF DIAGNOSIS): _____

STILL RECEIVING CHEMO/RADIATION: YES OR NO IF NO, DATE OF LAST CHEMO/RADIATION: _____

HOSPITAL WHERE RECEIVING TREATMENT: _____

INTENDED USE OF FUNDS (COPIES OF BILLS MUST BE INCLUDED)

Bill #1

Bill #2

Bill #3

Make Check Payable To:

Make Check Payable To:

Make Check Payable To:

Amount: _____

Amount: _____

Amount: _____

Send Payment To:

Send Payment To:

Send Payment To:

Requests cannot be approved without submitting a current copy of the bill to be paid. If more than 3 bills are being requested, please attach a separate piece of paper with payment information.

TOTAL AMOUNT REQUESTED: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ SOCIAL WORKER SIGNATURE: _____

By signing this application, you are giving permission to your medical professionals and their constituents to share your child's medical condition to the ThinkBIG Pediatric Cancer Fund, ThinkBIG Board of Directors, and ThinkBIG Allocations Committee.

INTERNAL USE ONLY

SIGNATURE OF ALLOCATIONS MEMBER: _____

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