

Outreach/Emergency Services Application

P.O Box 1138 Bothell, WA. 98041

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peplaxco@msn.com

www.childhoodcancercare.org

Circle Hospital Location: **Mary Bridge—Fred Hutch-U.W.—Children's—Madigan**

Childs Name _____ Diagnosis _____

Diagnosis Date _____ Treatment Length of Treatment _____ Birthdate _____

Please add us to the Family Mailing list Yes _____ No _____ (newsletters & family events)

Emergency Services Program Request: (food gift certificates) Fred Meyer _____ Safeway _____

Alberton's _____ Top Foods _____ Other _____ Phone Card _____ Gas Card _____ Car Repair _____

Repair _____ Electric _____ Phone _____ Medical Co-pay _____ Other utility _____ Car Tabs _____

Funeral assistance _____ Other _____

Parent Information

Name of Parent(s): Dad _____ Mom _____

Permanent Address: _____

Phone: _____ Email: _____

Temporary Address (if applicable):

City, State & Zip: _____

Temporary Phone: () _____

Father's / Guardian's Employer:

Mother's / Guardian's Employer:

Child Information

Patient's Name: _____ Date of Birth: _____ Male _____ Female _____

Sibling's Name: _____ Date of Birth: _____ Male _____ Female _____

Sibling's Name: _____ Date of Birth: _____ Male _____ Female _____

Sibling's Name: _____ Date of Birth: _____ Male _____ Female _____

Sibling's Name: _____ Date of Birth: _____ Male _____ Female _____

Social Worker: _____ Diagnosis: _____ Date of Diagnosis: _____

Has the child finished treatment, if so when? _____

Please use this space to share your story with us, include why you need this assistance and how your child and family will benefit. Be specific about the financial impact your child's diagnosis has had on your family. Attach additional pages if necessary.

Parent Signature: _____ Date: _____

Doctor/CNS/Social Worker Signature: _____ Date: _____

***Please call us prior to faxing or mailing this completed this form, thank you**

****Child must be associated with one of these treatment hospitals**