



**Outreach & Emergency Services Application**

Childhood Cancer Careline, *Giving from the Heart*  
 PO Box 1138 | Bothell, WA 98041  
 P 425.870.5622 | F 425.577.6362  
 www.childhoodcancercare.org | info@childhoodcancercare.org

*When we receive your application, please allow 72 hours for review. A member from the organization will call you to confirm that we have received your application. If you do not receive a call within the allotted time for processing means, we have not received your application.*

HOSPITAL INFORMATION	EMERGENCY SERVICE REQUEST
<input type="checkbox"/> Mary Bridge <input type="checkbox"/> Fred Hutch/UW/SCCA <input type="checkbox"/> Children’s Hospital <input type="checkbox"/> Madigan <input type="checkbox"/> Other	<input type="checkbox"/> Food / Gas Card <input type="checkbox"/> Utilities Bill* <input type="checkbox"/> Phone Bill* <input type="checkbox"/> Rent / Mortgage* <input type="checkbox"/> Auto Repair*

PATIENT INFORMATION	
Patient Last Name:	Patient First Name:
Diagnosis:	Date of Diagnosis:
Treatment:	Length of Treatment:
Social Worker:	Has the child finished treatment? If so, when? <input type="checkbox"/> Yes <input type="checkbox"/> No
DOB:	Phone Number:

FAMILY INFORMATION	
Mother’s Name:	Father’s Name:
Address:	Address (if different):
Phone Number:	Phone Number (if different):
Email Address:	Email Address (if different):
Mother’s Employer:	Father’s Employer:
Is Mother living with child?	Is Father living with child?

PARENT TEMPORARY LIVING INFORMATION	
Temporary Address:	Room Number:
Phone Number:	Expected length of stay:

SIBLING(S) INFORMATION			
Last Name:	First Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:	First Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:	First Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Last Name:	First Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female

*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. (\*Please provide proof of ownership of vehicle, copies of utility bills and rental agreements when asking for assistance in that category. Attach additional pages, if necessary.)*

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Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor / CNS / Social Worker Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor / CNS / Social Worker Phone Number