

Alessia Maria's Light of Love Foundation
Family Financial Assistance Application
PATIENT & FAMILY INFORMATION

Date of Application: _____

Child's First & Last Name: _____

Preferred Name: _____ **Age:** _____ **DOB:** _____

Sex: _____

Parent/Guardian Name(s):

Parent/Guardian Phone: _____

Email: _____

Mailing Address:

City: _____ **State:** _____ **ZIP:** _____

Child's Clothing Size (optional): _____

Diagnosis & Treatment

Brain Tumor Diagnosis: _____

Date of Diagnosis: _____

Current Treatment/Status: _____

Treatment Hospital: _____

City & State: _____

Family Information

Names and Ages of Siblings:

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Adults Living in the Household & Occupations:

Does the child have medical insurance?

☐ Yes ☐ No

Insurance Provider: _____

Approximate Annual Household Income:

- ☐ Under \$25,000
☐ \$25,000–\$75,000
☐ \$75,000–\$150,000
☐ Over \$150,000

Has the family received assistance from Alessia Maria's Light of Love Foundation previously?

☐ Yes ☐ No

If yes, please provide details:

Is the family currently seeking or receiving assistance from any other organization?

☐ Yes ☐ No

If yes, please list:

How did your family learn about the Light of Love Family Assistance Program?

Any other details you think we should know?

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**MEDICAL PROVIDER / HOSPITAL / SOCIAL WORKER
INFORMATION**

Hospital Name, Phone Number & Address:

Medical Provider/ Oncologist Name, Phone Number & Address:

Social Worker Name, Phone Number & Address:

REQUEST FOR ASSISTANCE

Total Amount Requested: \$_____

Please attach copies of all bills or invoices associated with this request.

Please provide a list of requested expenses:

Expense	Provider	Account #	Amount
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Please attach additional pages if necessary.

Bills and invoices should clearly show the provider's **name, mailing address, account number, and amount due.**

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ADDITIONAL FAMILY INFORMATION

Please provide any additional information about the family's circumstances that you feel would help the Foundation understand your current needs.

CERTIFICATION & SIGNATURES

By signing below, I confirm that:

- The information provided in this application is true and accurate to the best of my knowledge.
- I am authorized to submit this application on behalf of the child and family.
- I understand that assistance is based upon the Foundation's review of the family's circumstances and available resources.
- I understand that submitting an application does not guarantee financial assistance.
- I authorize the Foundation to contact the hospital social worker or medical provider regarding this application if additional information or clarification is needed.

Parent/Guardian

Signature: _____

Printed Name: _____

Date: _____

Medical Provider OR Hospital Social Worker

Signature: _____

Printed Name: _____

Date: _____

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PHOTO & STORY RELEASE

We believe that sharing Alessia's story and the stories of the families we support can help spread kindness, hope, and awareness. However, **participation in photographs, stories, social media, or publicity is completely voluntary and is not required to receive a wish.**

☐ **YES**, I give Alessia Maria's Light of Love Foundation permission to use photographs and/or my child's story for Foundation-related awareness, fundraising, educational, or promotional purposes.

☐ **NO**, I do not give permission for photographs or my child's story to be used publicly.

Child's Name: _____

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Please Email the completed application to info@alessiamariaslightoflovefoundation.org

A LITTLE LIGHT. A LITTLE LOVE. A LASTING IMPACT.



Created in honor of Alessia Maria, whose light continues to shine, whose love continues to grow, and whose legacy will live on through every family we are able to help.

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FOR FOUNDATION USE ONLY

Date Application Received: _____

Date Reviewed: _____

Decision:

- ☐ Approved
- ☐ Partially Approved
- ☐ Not Approved
- ☐ Additional Information Requested

Amount Approved: \$ _____

Payment(s) Made To:

Date Payment Issued: _____

Foundation Representative: _____

Notes:

