

# André Sobel River of Life Foundation

## Everyday Needs Assistance Program

*For Single Parent Families of Children with Life Threatening Illnesses*

We are pleased to assist your family by paying for urgent everyday needs during your child's treatment and when all other resources are exhausted. Kindly have your child's social worker fill out this form and fax back to 310-276-0244, or email to [niki@andreriveroflife.org](mailto:niki@andreriveroflife.org)

**TO AVOID PROCESSING DELAYS PLEASE PRINT LEGIBLY**

Rev 9/2015

Hospital Name:	Date:
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Social Worker's Name:	Telephone:
E-mail:	Fax:

Parent's name(s):	Single Parent <input type="checkbox"/> yes <input type="checkbox"/> no
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Child's name:	Age:
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Home Address:
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City:	State:	Zip:	Phone:
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Siblings' ages and gender:
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Physician's name:	Date of initial diagnosis:
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Brief description of illness:	Currently hospitalized: <input type="checkbox"/> yes <input type="checkbox"/> no
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Detailed description of the family's circumstances and the reason for requesting financial support:
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Members of household: <input type="checkbox"/> Mother <input type="checkbox"/> Father # <input type="checkbox"/> Siblings # <input type="checkbox"/> Grandparent(s) # <input type="checkbox"/> Others _____
Housing: <input type="checkbox"/> Owns <input type="checkbox"/> Rents <input type="checkbox"/> No current home <input type="checkbox"/> Lives with others _____
Explanation: _____
Family resources: <input type="checkbox"/> Mother works <input type="checkbox"/> Father works <input type="checkbox"/> Siblings work <input type="checkbox"/> Other family support
Explanation: _____

## Assistance Currently Received by the Family

*Please put a check mark next to resources for which you have applied.*

American Brain Tumor Association	Leukemia & Lymphoma Society
American Cancer Society (ACS)	Medi-Cal
Angel Flight	National Assoc. for the Terminally Ill
AVONCares Program	National Children's Cancer Society (NCCS)
Candlelighters Childhood Cancer Foundation (CCCF)	New Economics For Women (NEW)
Care Resource Center (CCRC)	Oral Cancer Foundation
Child Care Resource List*	Patient Access Network Foundation (PAN)
Co-Pay Relief Program (CPR)	
Food Assistance Support*	Public Utilities Programs*: phone gas electric/water
Food Stamp Program	Religiously Affiliated Charities*
General Relief (GR)	Section 8 Housing (by area)
Health Insurance Assistance Service (HIAS/ACS)	Social Security Disability (SSD)
Homeless Shelters (various)*	Spencer Crawford Children's Foundation, Inc
Hospice Assistance Program*	Supplemental Security Income (SSI)
Housing Assistance*	Temporary Aid to Needy Families (TANF)
In-Home Supportive Services (IHSS)	Transportation/Travel Assistance*
Lance Armstrong Foundation	Other:

**PLEASE PROVIDE A SUMMARY OF FAMILY'S AVAILABLE INCOME.**

**If available, please provide copies of bills for which assistance is requested. ASRL will use this information to pay vendors directly. Use additional sheet if necessary.**

**Specific request #1:**

Purpose: \_\_\_\_\_ Due Date: \_\_\_\_\_

Payee: \_\_\_\_\_ Amount requested: \_\_\_\_\_

Mailing address & phone: \_\_\_\_\_

Account Number: \_\_\_\_\_

Send to:  Social worker  Payee  Other \_\_\_\_\_

**Specific request #2:**

Purpose: \_\_\_\_\_

Due Date: \_\_\_\_\_

Payee: \_\_\_\_\_ Amount requested: \_\_\_\_\_

Mailing address & phone: \_\_\_\_\_

Account Number: \_\_\_\_\_

Send to:  Social worker  Payee  Other \_\_\_\_\_

**Specific request #3:**

Purpose: \_\_\_\_\_

Due Date: \_\_\_\_\_

Payee: \_\_\_\_\_ Amount requested: \_\_\_\_\_

Mailing address & phone: \_\_\_\_\_

Account Number: \_\_\_\_\_

Send to:  Social worker  Payee  Other \_\_\_\_\_

We ask permission to use your information in an effort to provide service and financial assistance for your family. This information may, with discretion, be shared on your behalf with service providers, utilities, landlords, etc. to aid and preserve your family's financial welfare. We may also use information in order to promote the charitable goals of the Andre Sobel River of Life foundation and its partner hospitals. If you do not want your information disclosed, please advise us, in writing, at the Andre Sobel River of Life Foundation, PO Box 361460, Los Angeles, CA 90036. If you do not want your information disclosed, this will not affect ASRL's willingness to assist your family.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Worker

\_\_\_\_\_  
Date

\*If parent/guardian has Limited English Proficiency, please add interpreter's signature attesting to interpretation in parent's home language.

