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

TO AVOID PROCESSING DELAYS PLEASE PRINT LEGIBLY

Rev 9/2015

Hospital Name: Date:

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

Parent's name(s): Single Parent ___**yes** ___**no**

Child's name: Age:

Home Address:

City: State: Zip: Phone:

Siblings' ages and gender:

Physician's name: Date of initial diagnosis:

Brief description of illness: **Currently hospitalized: ___ yes ___ no**

Detailed description of the family's circumstances and the reason for requesting financial support:

Members of household: __Mother __Father #__ Siblings # __Grandparent(s) # __Others_____

Housing: __Owns __Rents __No current home __Lives with others_____

Explanation:_____

Family resources: __Mother works __Father works __Siblings work __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.

ANDRE SOBEL
RIVER OF LIFE
FOUNDATION