



RUNWAY to HOPE

FAMILY ASSISTANCE PROGRAM APPLICATION

Runway to Hope is honored to be able to review your Family Assistance Application and learn more about your family's story. Runway to Hope serves the Greater Central Florida pediatric cancer community and the three main children's hospitals: Arnold Palmer Hospital for Children, The Florida Hospital for Children, and Nemours Children's Hospital.

Child's Name: _____ Date of Birth: _____

Type of Cancer: _____ Date of Diagnosis: _____

Hospital Affiliation: _____ Social Worker: _____

Oncology Doctor: _____ Currently Being Treated? YES NO

Parent/Guardian Name: _____ Last 4 of SSN *: _____

Phone Number: _____ Alt. Phone Number: _____

Email: _____

Address: _____

Total Family Size: _____ Total Household Annual Income: \$ _____

Family Income Sources: Salary SSI Child Support TANF Other _____

Please include proof of salary or a bank statement to verify income sources.

Guardians Employer: _____

Is Parent/Guardian on unpaid leave? YES NO

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Have you /your child participated in the Runway to Hope Spring Fashion Soiree? YES NO

If no, how did you find out about Runway to Hope? _____

Tell us your story: _____

What type of assistance are you seeking and why? (please be as specific as possible)

Please include your expenses below and attach a copy of the bill(s) requested if applicable.

Expense: _____	Amount: \$ _____
Expense: _____	Amount: \$ _____
Expense: _____	Amount: \$ _____
Expense: _____	Amount: \$ _____

Are any of the expenses past due? YES NO

If yes, how many days/months past due?

Special request(s):

Have you or your family received assistance from other non-profit organizations? YES NO

If so, please include organization name(s) and reason for assistance: _____

Date of Assistance: _____	Amount: \$ _____	Bill Paid: _____
Date of Assistance: _____	Amount: \$ _____	Bill Paid: _____
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