



BENJI WATSON CANCER FOUNDATION

ASSISTANCE APPLICATION

Child's Name: _____

Date of Birth: _____

Date of Diagnosis: _____

Type of Child's Cancer: _____

How did you find out about the Benji Watson Cancer Foundation?

Name of Social Worker: _____

Your Name: _____ Relationship to Child: _____

Total Family Size: _____ Annual Family Income: _____

Phone Number: _____

Mailing Address: _____

Email Address: _____

What type of assistance can we provide? Please be as specific as possible, include copy of billing statement if applicable.

EXPENSE: _____ AMOUNT: _____

EXPENSE: _____ AMOUNT: _____

EXPENSE: _____ AMOUNT: _____

EXPENSE: _____ AMOUNT: _____

Have you and/or your family received help from other organizations? Yes No

If yes, include the organization's name/s:

Can the Benji Watson Cancer Foundation contact you to share your story to help other children and families in need? Yes No *I hereby release the rights of this information to be used by the Benji Watson Cancer Foundation at any time they may deem it helpful to use in their efforts to raise more money for children and families battling cancer. I understand that my story may be shared via a number of different formats with the public, including written, video, audio, or photographic.*

Signature _____ Date: _____