Bereavement Fund

I, _____ have received your offer of financial assistance for the payment of memorial costs for my child. I authorize Kids Cancer Alliance Staff to contact those associated with my child's memorial and make payments on my behalf. I understand that Kids Cancer Alliance reserves the right to deny payment if the expense falls outside of the scope of the Bereavement Fund. I understand that the Bereavement Fund will cover up to $5,000 of assistance and anything beyond that amount is my responsibility. I give permission to Kids Cancer Alliance to use my child's name in a memorial at camp (totum/memory pole) or another program as a way to honor my child and their memory.

Patient Information

Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Additional Information

Funeral Home: _____

If Kids Cancer Alliance has any questions, who should we contact? Contact Me ☐ Contact person on my behalf ☐

Name: _____ Phone: _____

Authorization

Parent/Guardian Signature: _____