Specialove

for children with cancer

THE KATHY RUSSELL

EMERGENCY RELIEF FUND

Financial relief fund created to assist families in need during their cancer journey

Special Love, Inc.
117 Youth Development Court
Winchester, VA 22602
1-888-930-2707
www.specialove.org

ABOUT THE FUND

The Kathy Russell Emergency Relief Fund helps families of children facing cancer treatment with everyday living expenses so they can focus on their struggle against cancer.

The fund is open to pediatric cancer patients (ages 25 and under) who are treated at facilities in the following states or districts:
Maryland
Pennsylvania
Virginia
Washington, DC
West Virginia

TYPES OF EXPENSES COVERED

- Utilities (electric, gas, phone) which are in danger of being shut off for non-payment
- Auto repairs that are necessary to allow a parent or caregiver to provide transportation to and from medical treatment
- Rent or mortgage payments
- Other emergency situations involving basic living expenses
- Funeral expenses

GUIDELINES FOR REQUESTS

- Requests should be made through a social worker, doctor, or other hospital representative familiar with the patient's family
- Requests must be accompanied by a copy of the bill for services. Bill should include family's name, address, where the service was provided, account number, and amount due.
- Social worker or hospital rep must complete the form and email to Judy Martin jmartin@specialove.org or fax to 540-667-8144

All payments are made payable to service provider, not customer/family.

GUIDELINES FOR ELIGIBILITY

Full fund eligibility is restricted to program participants who are or have been participants of at least one camp, adventure, or family program sponsored by Special Love, Inc.

Families may request assistance multiple times in one calendar year, with an annual limit of $2,000

Non-participants of Special Love programming may receive a one-time assistance grant of $500

EMERGENCY RELIEF FUND REQUEST FORM

Patient Name: ______________________________________

Address: ____

City, State, Zip: ____

Home Phone: _______________________

Parent or Caregiver's Name: ____________________________

Address (if different): ____

____

Description of Expense (Must attach Bill/Invoice):

____

____

____

____

Amount Requested: $________________ Date Needed: ______________

Patient Birthdate: ___________________ On/Off Treatment: _________

Date of Diagnosis: ___________________

If Off Treatment, Date of Last Treatment: ______________________

Diagnosis: ________________________________

Hospital Treatment Location: ___________________________________

Name & Title of Requester: _____________________________________

Requester Email: ______________________________________

Requester Phone: _______________________________

DON'T FORGET TO ATTACH THE BILL/INVOICE