# APPLICATION FOR
# LIFE ASSISTANCE

PLEASE PRINT

LEA'S FOUNDATION FOR LEUKEMIA RESEARCH INC

Date _____

Applicant's / Patient's Name _____

Parent/Guardian Name _____

Address _____

City_____State_____Zip _____

Phone _____Age_____Date of Birth _____

Email Address _____

Diagnosis _____Date Diagnosis_____Type _____

Physician's Name _____Phone _____

Address _____

City_____State_____Zip _____

Physician's Signature _____

Proposed use of funds:

- ☐ Housing
- ☐ Rent
- ☐ Utilities
- ☐ Child Care
- ☐ Loss of Work
- ☐ Other- Essential Living Expenses
- ☐ Other: _____

Signature Parent/ Guardian _____Date _____

Printed Signature _____

**Please complete and return to:**

**Lea's Foundation for Leukemia Research, Inc.**
**Patient Services Committee**
**522 Cottage Grove Road**
**Building H**
**Bloomfield, CT 06002**

Rev. 2/2016