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

www.specialove.org/financial-relief
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