JOSH FARLER FOUNDATION  
www.joshfarler.org

JOSH FARLER FOUNDATION CANCER BENEFIT APPLICATION

* REQUIRED INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \*APPLICANT NAME: | | | | |
| \*STREET ADDRESS: | | | | |
| \*CITY: | \*STATE: | | | \*ZIP CODE: |
| \*HOME NUMBER: | | | CELL NUMBER: | |
| \*PARENT/LEGAL GUARDIAN NAME: | | | | |
| \*ARE YOU A STUDENT: | | GRADE: | | AGE: |
| \*DIAGNOSIS: | | | | |
| \*TREATMENT (TYPE): | | | | |
| \*ADDRESS/DESTINATION FOR TREATMENTS? | | | | |
| \*HOW OFTEN TRAVELED TO ABOVE LOCATION? | | | | |
| \*ESTIMATED DURATION TRAVEL WILL BE REQUIRED? Include total past/future | | | | |
| \*IF OUT OF TOWN, IS OVERNIGHT STAY REQUIRED? | | | | |
| \*ARE YOU INSURED? PLEASE ESTIMATE YOUR OUT OF POCKET PAYMENTS MONTHLY? | | | | |

\*Please tell us about yourself, your story, your family, why you are applying as a recipient of the Josh Farler Foundation, what will being an awarded recipient do for you? (Attach addition page if needed)



If you choose you may submit a picture and any additional information you would like.

\* Required A) an appointment card or doctors statement verifying the location/frequency of treatments B) proof of address applicants address

Mail your application to:  
Attn: Judy Simmons  
c/o Josh Farler Foundation  
4817 Margalo Ave  
Bakersfield CA 93313

(661) 834-1956

Return via email to:  
[judy.simmons@joshfarler.org](https://wcc.godaddy.com/email?cmd=planlistemail&locale=en-US)

PLEASE KNOW YOU AND YOUR FAMILY WILL BE IN OUR PRAYERS & WE WILL BE IN CONTACT SOON!!