Please complete this form so that we can customize your child's gift
Please email completed form to programs@sarahsfightforhope.org

Grants limited to NJ residents Only

Personal Contact Information:

Patient's Name: _____ DOB: _____

Mother's Name: _____

Father's Name: _____

Address: _____

City: _____ State: **Limited to NJ Only** Zip: _____

Email Address: _____

Medical Information:

Diagnosis: _____ Date of Diagnosis: _____

End of Treatment Date: _____

Treating Hospital: _____

Full name of Social Worker: _____ Email: _____

Social Worker's Direct phone/extension: _____

Which gift Program are you applying for? (please check one)

☐ **Basket of Hope** - this gift if for a child, age 0-19 who has been diagnosed within six months of request

☐ **Celebrating Hope** – this gift is for a child who will be inpatient during their birthday

☐ **Beauty of Hope** – this gift is for teen girl age 13-19 in active treatment. Receive a gift certificate for a local spa/salon for a manicure, pedicure, teen facial or a massage. *Must have MD clearance for this service.*

The following information is required for Basket of Hope and Celebrating Hope grants.

Patient Information:

Patient's Favorite Color: _____

Patient's favorite Cartoon or TV Character: _____

Patient's Favorite Sport/Sports Team:_____

Patient's Favorite Activity/Hobby/Interest:_____

Patient's Favorite Candy/Snack: _____

Patient's Favorite stores: _____

Clothes size: Shirt: _____ Pants: _____ Shoe/Slipper: _____

Please tell us all the wonderful things we should know about your warrior to help us customize their gift.

_____

_____

The following information is required for our Beauty of Hope grant.

Name of Salon/Spa: _____Website Address: _____

City:_____ State: **Limited to NJ Only** Zip:_____

Phone Number: _____

Please select one option:

☐ Manicure ☐ Pedicure ☐ Mini-Facial ☐ Massage

Additional Family Information *(On occasion we like to recognize siblings for supporting their brother/sister during their battle. We know "No One Fights Alone" and it's important to us that siblings be recognized, and their spirits be lifted as well)*

Name of Siblings: 1) _____2) _____3) _____

Date of Birth of Siblings: 1) _____2) _____3) _____

Social Media:

Do you have any social media pages/links that journal your experience with pediatric cancer?

Facebook _____Caring Bridge _____

Go Fund Me _____ Other _____

Authorization/Release Form

For Parent(s) and Patient:

This shall serve to authorize Sarah's Fight for Hope Foundation, Inc. to utilize, publish or otherwise expose photographs, drawings, or any other likeness or image and any biography, story or any other information provided regarding patient name_____. Should patient be a minor, legal guardian will sign for the purpose of reporting to the Trustees or for press release or display at fundraising events or any on line display on Sarah's Fight for HOPE Foundation page or Sarah's Fight for HOPE Foundation website.

** By signing this application, you are attesting to the accuracy of the information on all pages, to the best of your knowledge. Fraudulent applications may result in your application being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.*

Parent(s) signature: _____**Date:** _____

Patient's signature (age 18 and over): _____

For Social Worker:

By signing this application, you are attesting to the accuracy and validity of the patient and medical information provided, including MD approval for Beauty of Hope grant.

Social Worker's Name (print) _____

Social Worker's Signature: _____ **Date**: _____

Reminder: Once complete, please email signed form to programs@sarahsfightforhope.org