Gifting Program Form

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 Full Name: ______________________________ DOB:______________ Gender: ☐ M ☐ F

Mother's Full Name: _________________________Father's Full Name: _________________________

Address: _______________________City:_________________ State: NJ Zip: ______________

Home Phone: _____________________________ Cell Phone: ______________________________

Email Address: ____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

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)

☐ Package 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 girls **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.

☐ Adventure of Hope: A special request for a much-needed escape from the reality of cancer treatment and hospital visits. Options include Broadway shows, Sports Events, Concert Tickets; a wish that would be impossible for parents to provide without the help of an outside resource.

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

Patient Information:

Favorite Color: ______________________________ Favorite Cartoon or TV Character: ______________________

Favorite Sport/Sports Team:_____________________ 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.

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

Name of Salon/Spa: ______________________________________Website Address: ______________________

City:__________________________ State: NJ Zip:____________Phone Number: _______________________

Please select one option: ☐ Manicure ☐ Pedicure ☐ Mini-Facial ☐ Massage

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

Requested Gift: ____

How will this gift benefit the applicant? ____

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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 are 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?

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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 the patient be a minor, the legal guardian will sign for the purpose of reporting to the Trustees or for a press release or display at fundraising events or any online 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 Sarah's Fight for Hope to continue granting special gifts to all our pediatric cancer warriors, it is important for us to share pictures and testimonials from your gift experience. This allows us to share with our generous donors to ensure we continue to have their support for our various programs.*

We would greatly appreciate it if you would email us at programs@sarahsfightforhope.org, and let us know how your special gift/program was and share some pictures with us.

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 the Beauty of Hope grant.

Social Worker's Name (print) ____

Social Worker's Signature: _________________________________ Date: _____________________________