Our mission at Sarah's Fight for HOPE is to be able to provide support to as many families of children battling cancer through our various Programs. The Foundation provides grants to minimize the financial hardship that is directly attributable to the child's illness.

REQUIREMENTS: New Jersey Residents ONLY. Child is currently in treatment and must be age 0-19

APPLICATION FOR FINANCIAL ASSISTANCE (To be completed by the child's parent/legal guardian, **PLEASE PRINT**)

PLEASE CHECK ONE: ☐ INITIAL APPLICATION: ☐ SUPPLEMENTAL APPLICATION:

PATIENT INFORMATION:

Child's First Name: _____ Last Name: _____

Circle One: Male/Female DOB: _____ (00/00/0000 format)

PARENT/GUARDIAN INFORMATION:

Parent/Legal Guardian's First Name: _____ Last Name: _____

Address: _____

City (Full Name): _____ State: **NJ Residents ONLY** Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

ANNUAL Household Income (i.e. government assistance, child support, alimony, family assistance, all sources of income to pay living expenses): $_____ Requested grant amount ($ amount required): _____

Intended use of grant – required (please provide copy of bill, with the vendor name, account number, mailing address, family's last name, and dollar amount owed). **All payments made directly to the vendor**

Please provide the following information for Financial Assistance provided by other Organizations and Foundations:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Amount Donated: $_____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Amount Donated: $_____

MEDICAL INFORMATION (To be completed by a social worker. PLEASE PRINT)

Child's Diagnosis: _____

Date of Diagnosis (Month-Day-Year):_____ Relapse (Month-Day-Year): _____

Currently Undergoing Active Treatment: ☐ Yes ☐ No

Child's Oncologist: _____

Hospital: _____

Hospital Address: _____

City (Full Name): _____State: _____ Zip Code: _____

Social Worker's Name (Full): _____

Social Worker's Direct Phone Number and Extension: _____

Social Worker's Email Address: _____

Please describe the child's medical condition, anticipated hospital stay, and any other notable facts (please attach a letter if needed):

_____

_____

_____

Social Workers Hand-Written Signature & Date

* I have reviewed and can validate the medical information provided in this grant request:

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

Parent/Legal Guardian's Hand-Written Signature & Date

* By signing this application, you are attesting to the accuracy of the information on both 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.
*Applications are reviewed during our monthly Board Meetings (2nd Tuesdays of the Month). All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted and the availability of funds.
* By signing this application, you are agreeing to allow publication of your child's name and medical condition by Sarah's Fight for HOPE Foundation. Additionally, by signing this, you are giving your medical professionals and Sarah's Fight for HOPE Foundation, permission to share medical information about your child's case. Finally, by signing this, you are consenting to allow Sarah's Fight for HOPE Foundation, to share your application with members of our Board and Advisory Committee for review and consideration of your financial request for assistance.

Parent/Legal Guardian's Signature:_____ **Date**: _____