Wishing for Mommy 2017 Application

Child Name: (First) _____ (Last) _____ Age: ___ Birthday : ___/___/_____

Child's Hobbies/Interests: _____

_____

Mommy Name: (First) _____ (Last) _____ Age: ___ Birthday : ___/___/_____

Address: _____City: _____ State: _____ Zip: _____

Email: _____ Phone Number: _____

Mommy's Hobbies/Interests: _____

_____

(If Adult nominating on behalf of a child, please complete the following)

Adult Assistant Name: (First) _____ (Last) _____ Age: _____

Relation to child: _____ Phone Number: _____

Email: _____ No. of Years You've Known the Family: _____

Please answer the following questions to the best of your abilities:

1.) Have you ever submitted an application to Wishing for Mommy in the past? Yes or No

2.) Is the child or mommy affiliated with a Martial Arts center at all? Yes or No

If yes, please name the instructor and city in which you train: _____ City: _____

3.) Please tell us how you heard about Wishing for Mommy: _____

_____

This page must be included with your One-page Story and Medical Eligibility form for your nomination to be considered for a grant.

My Wish for Mommy– 1 Page Story

Name: _____

In your story, try to tell us what you would do with $500 if you were given this money to help your mommy out while she is struggling with Breast Cancer or recovering. Some wishes have been to take mommy to the beach, on a vacation, pay to have a relative fly in to visit, have a makeover, redecorate her room, or even just help with the bills. What is your wish?

2017 Medical Eligibility Form

Dear Health Care Professional,
The person from whom you are receiving this form is requesting that you fill out the following information in its entirety in order for them to continue the application process for a Wishing for Mommy Grant. Please contact us directly if you have any questions about this document or its use. Thank you! -Dignity Kids, Inc.

PATIENT INFORMATION (please print clearly)

FIRST NAME: _____ LAST NAME: _____ DATE:_____

ADDRESS:_____

PHONE NUMBER: HOME (_____) _____ WORK (____) _____

CELL (____) _____ E-MAIL ADDRESS: _____

DATE OF BIRTH: _____

MEDICAL INFORMATION *THIS SECTION MUST BE COMPLETED BY ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR HOSPTIAL ACS PATIENT NAVIGATOR ONLY *

DATE OF DIAGNOSIS: _____ STAGE OF CURRENT BREAST CANCER: □1 □2 □3 □4

□NEW DIAGNOSIS □RECURRENCE IS PATIENT IN ACTIVE TREATMENT? □YES □NO

IF NOT IN ACTIVE TREATMENT, indicate frequency of follow-up: □YEARLY □EVERY SIX MONTHS

□OTHER: _____

HEALTH CARE PROFESSIONAL INFORMATION (please print):

MD NAME: _____ HOSPITAL/CLINIC: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: (____) _____ FAX: (____) _____

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):

NAME: _____ PHONE: _____

RELATIONSHIP TO PERSON APPLYING FOR GRANT: □DOCTOR □NURSE □SOCIAL WORKER □ACS HOSPITAL PATIENT NAVIGATOR

SIGNATURE OF PROFESSIONAL: _____ _____

INCOMPLETE FORMS CANNOT BE ACCEPTED. THANK YOU.

Dignity Kids Inc. will review this information and contact the person requesting the Wishing For Mommy Grant.

All information is strictly confidential and is for Dignity Kids Inc. use only.

Wishing For Mommy 610 N. Alma School Rd. #32 Chandler, AZ 85224 (480) 831-1111