Arms Wide Open Childhood Cancer Foundation, Inc.
P.O. Box 258
Marlboro, New Jersey 07746

Family Information

Patient's Name: ____

Birth Date: _____________(must be 21 or under to qualify) Gender: Male/Female (please circle)

Address: ____

City: _______________________________________ State: _________ Zip Code: __________

Telephone: ___________________________ Email Address: ____________________________

Name of Parent(s) or Guardian(s): ____

Siblings and/or Other Family Members at Same Address: ________________________________

____

Annual Income as Reported on Your Most Recent Tax Return: ____________________________

Health Information

Diagnosis: ____

Date of Diagnosis: ____

Name of Oncologist/Physician: ____

Hospital/Treatment Facility: ____

Referring Social Worker/Case Manager: ____

Telephone: _________________________________ Fax: __________________________

Email Address: ____

If you feel comfortable, please provide your race. We only collect this data to be able to show the diverse population childhood cancer affects in order to obtain grant funding. Check all that apply.

____ White ____ Black or African American ____ American Indian or Alaska Native ____ Asian

____ Native Hawaiian ____ Other Pacific Islander ____ Hispanic or Latino ____ Prefer Not to Answer

I have reviewed this application and, to the best of my knowledge, this information is true and correct.

Parent/Guardian Signature: ____ Date: ____________

Social Worker/Case Manager Signature: __________________________________ Date: ___________

Briefly state reason for requesting grant: ____

____

Please e-mail completed form to Kristen at kristen@awoccf.org.