



Requested Grant Amount: _____

Indicate How Grant Monies Will be Spent if Awarded:

HEROES GRANT PROGRAM APPLICATION

Patient Name: _____ Patient Age: _____ Birthdate: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Email Address: _____

Hospital Name: _____ Phone: _____

Oncologist Name: _____ Phone: _____ Email: _____

Social Worker Name: _____ Phone: _____ Email: _____

Patient's Story: Tell us about You. What was life like before you were diagnosed? What is it like now?

Need Statement: What is the need or dream an Ishan Gala Foundation Hero Grant could help you fulfill?



Promotional Release:

Please select and sign below to grant the Ishan Gala Foundation the right to use the patient and family's names, story and pictures to help raise awareness for the Ishan Gala Foundation, and to increase awareness of neuroblastoma and pediatric cancer and the need for funding for an unlimited period of time in all media.

- Yes, I agree to allow the Ishan Gala Foundation use all information.
- No, I would like to keep all information confidential

Parents Signature: _____ Date: _____

Print Name: _____

Oncologist/Social Worker's Signature: _____ Date: _____

Print Name and Title: _____

Attachments Required:

- Attach a Photo of the Patient Before and After his/her diagnosis
- Attach a letter on Hospital Letterhead verifying the patient's diagnosis signed by the treating oncologist and/or hospital social worker.