Sanctuary Friends Network is a non-profit organization that provides vacation experiences for cancer patients and their families. The organization is run by a God-centered group of volunteers who are committed to bringing peace, joy, and memories to our families during the hardest season of their lives. Many of our members have walked in your shoes, they know the struggles and they want to be a part of your healing experience.

Our wish is that we can grant everyone's wish; but the reality is, we have a limited amount of funds based on what has been generously donated and fundraised for us. Many of the families we assist are through word of mouth and former participants. We help with providing accommodations, most meals, excursions, and professional photography during your stay.

Pay It Forward: Our hope is that you or your family and friends will join us later to assist another patient and their family.

Step 1: Complete Application

Step 2: Complete Medical Release Form and have professional fill out their form

Step 3: Go over the Checklist of Application Materials (if all items are not in place, then an application will not be reviewed).

APPLICATION FOR VACATION CHECKLIST

Check list of all documentation we will need to complete your application:

- ✓ Completed application with signatures and release of information checked off.
- ✓ Copy of driver's license or other photo ID (state photo ID, college/school photo ID).
- ✓ Medical release filled out by Oncologist/Oncology Social Worker (we need original release; please mail with application). Include a note from them whenever possible on letterhead.
- ✓ Include a brief letter or video telling us about yourself and/or how cancer has affected your life (limit to 500-word essay).
- ✓ Please let us know how this trip would help your family. Your story is important to us: it will let us know who you are and help bring awareness to other families with cancers. A photo and/or video can be included with your letter.

APPLICATION FOR VACATION GRANT

Name of patient: _____Gender: _____

Name of Spouse: _____

Parent or Legal Guardian Name: _____

Address: _____

City:_____ State:_____ Zip:_____ Date of birth: _____/_____/_____

Home phone: _____ Cell Phone: _____

Email address: _____

Desired dates of vacation in Destin, Florida **OR** Keystone, Colorado. Please specify which location:

_____

Desired activities for family: _____

_____

Number of family members in the immediate household: _____

Name, gender, and age of family members:

	Name	Gender	Age
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____

Does the patient have any physical limitations special needs we need to be aware of? If so, please explain:

_____

_____

Signature of Patient: _____Date: _____

Or Signature of Parent or Legal Guardian if patient is under the age of 18:

_____

Have you received help from another organization? _____

If yes, who and what was granted (will not affect your application): _____

_____

_____

_____

Sanctuary Friends Network, Inc. Please contact us with any questions at sanctuaryfriendsnetwork@gmail.com

Release to use information & photos:

Sanctuary Friends Network would like your permission to share information on our website or during fundraising events to promote awareness and increase support. This could include your picture, letter, and/or a quote from you. We do NOT share your information with other organizations. (Please refer to our Privacy Statement). Check preference:

____I give permission for Sanctuary Friends Network, Inc. to use my name, photo, and information as they need.

____I give permission for Sanctuary Friends Network, Inc. LIMITED use of my name, photo, and information:

SPECIFICATION OF USE: _____

_____

____ I do NOT give Sanctuary Friends Network, Inc. permission to use my name, photo, or information.

How did you hear about Sanctuary Friends Network? _____

_____

SECTION A: MEDICAL RELEASE OF INFORMATION TO

Sanctuary Friends Network, Inc.

To be completed by Physician or Oncology Social Worker

Your professional role

(Check one- only professionals in roles listed here may complete this verification form):

Physician Oncology Social Worker Other _____

2. Name of Patient: _____Patient's date of birth: ____/____/___

3. Patient's diagnosis (you may attach information on a separate sheet with letterhead): _____

4. Date of diagnosis: _____

5. Current treatment: _____

6. Any ongoing medical issues related to treatment or cancer: _____

7. How long have you been treating this individual? _____

8. I currently see this individual:

Daily Weekly Monthly Other (specify) _____

Signature of Professional: _____Date: _____

PLEASE PRINT PROFESSIONAL INFORMATION:

Name: _____ Title:_____

Hospital Affiliation: _____

Address: _____Phone: _____

Email: _____

Please contact us with any questions at sanctuaryfriendsnetwork@gmail.com

SECTION B: MEDICAL RECORDS RELEASE TO:

Sanctuary Friends Network, Inc.

To be completed by Patient

I authorize the professional identified in Section A to release the information on this form to Sanctuary Friends Network, Inc. I also authorize the professional to speak to a representative from Sanctuary Friends Network, Inc. to verify information if needed for a grant I am requesting. (Please refer to our Privacy Statement)

Signature of Patient:_____ Date: _____

or Signature of Parent/ Legal Guardian if patient is under the age of 18.

_____

PLEASE PRINT:

Name of Patient:_____

Address of Patient:_____

Phone:_____Email:_____

THIS AUTHORIZATION EXPIRES IN 90 DAYS AFTER IT IS SIGNED

Privacy Statement

The privacy of your personal and medical information is important to the Sanctuary Friends Network. We are committed to protecting your information. Your records will be conscientiously maintained by the Sanctuary Friends Network and its Grant Committee following federal United States Health & Human Services HIPAA regulations.

In order to uphold the level of service that you expect from our organization, we may need to share limited personal information in the following ways:

- For coordination of excursions & housing while travelling
- To verify information from your doctor and/or health practitioner
- To obtain funding for Sanctuary Friends Network (statistics that do not include your name will be used in this situation)
- With board members and grant committee members of Sanctuary Friends Network to make decisions for your application

Sanctuary Friends Network does not discriminate on the basis of race, creed, color, ethnicity, national origin, religion, sex, sexual orientation, gender expression, age, height, weight, physical or mental ability, veteran status, military obligations, and marital status.