



## Healing Hearts Society Request for Funding

Date: \_\_\_\_\_ Amount requested: \$ \_\_\_\_\_ Date funds needed by: \_\_\_\_\_

### Referring Agency information:

Referring Agency: \_\_\_\_\_

Referred by: \_\_\_\_\_ Job Title: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

### Family Information:

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Death: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Child's special need: \_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_

Funds to be used for: \_\_\_\_\_

Check to be made payable to: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime telephone: \_\_\_\_\_ Other telephone: \_\_\_\_\_

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### For office use only:

Approved  Amount: \$ \_\_\_\_\_ Denied

Notes: \_\_\_\_\_

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Check request submitted  Date: \_\_\_\_\_

Funds dispersed:  Mailed to: \_\_\_\_\_ Date: \_\_\_\_\_

Hand delivered to \_\_\_\_\_ Date: \_\_\_\_\_

HHS.application.030507

Submit this form to Family Resource Network, 5250 Claremont Ave., Suite 239, Stockton, CA 95207 Fax: 209-472-3673 Email:FRNfamilies@aol.com

Healing Hearts Society  
Request for Funding  
Application Instructions

**Date:** Date of application.

**Amount Requested:** Not to exceed \$250.00

**Date funds needed by:** mm/dd/yy

**Referring Agency information:**

**Referring Agency:** Agency making the referral

**Referred by:** Name of referring individual

**Job Title:** Job Title of referring individual

**Telephone:** Daytime phone number(s)

**Email:** Email address for sponsoring individual (provides direct contact to referring individual, not just to that person's agency)

**Family Information:**

**Child's Name:** Legal name of child, including first and last name.

**Date of Birth:** Child's date of birth, mm/dd/yy

**Date of Death:** Child's date of death, mm/dd/yy

**Child's Special Need:** Disability, diagnosis or identification of special need.

**Parent(s) Name(s):** Legal name(s) (first and last).

**Funds to be used for:** Description of how funds will be spent, i.e. defray funeral costs, purchase headstone, etc.

**Check to be made payable to:** Name of person/agency/business receiving funds. This could be the child's family, or a person or business that provided a service such as a funeral home.

**Relationship to child:** Identify the relationship, such as parent, family member, business providing service, etc.

**Street address:** Address of person/agency/business receiving funds.

**Mailing address (if different):** If appropriate.

**City:** Spell out city name

**State:** State

**Zip Code:** Must be at least 5 digits

**Daytime telephone:** Phone number of family, in case HHS needs to contact family.

**Other telephone:** Other contact info such as cell phone or message phone.

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