

# Children's Security Blanket Project, Inc.

## *"Providing Hope for the Future"*

Social Worker Name: \_\_\_\_\_ Hospital: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Diagnosis: \_\_\_\_\_

Is Patient off Treatment? \_\_\_\_\_ If yes, how long? \_\_\_\_\_

Has your family received previous assistance from Security Blanket Project, Inc.?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, date and amount of funding? \_\_\_\_\_

Reason for previous request: \_\_\_\_\_

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

Sibling(s) & Age(s): \_\_\_\_\_

Address where child resides: \_\_\_\_\_  
*(must be in Spartanburg County, SC)*

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

Home Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Brief Explanation of Need/Request for Assistance: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date funds are needed? \_\_\_\_\_

Any Additional Comments: \_\_\_\_\_

\_\_\_\_\_

**Request must be accompanied by supporting documentation including receipts, current bills, and doctor's verification of treatment dates/services rendered.**

*Mail request to:*

Children's Security Blanket Project  
P.O. Box 18064 Spartanburg, SC 29318