HEALING PATCH
A Children's Grief Program

Family Application

Date:_____

Name of person filling out this form: _____

Your relationship to the child(ren): _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

County: _____ **Phone:** _____

Email: _____

Place of work: _____ **Work phone:** _____

Name of deceased: _____ **Date of death:** _____

Relationship of the deceased to the child(ren): _____

Please explain the circumstances (e.g. cause of death plus any other information that you feel is important):

_____

_____

_____

_____

CAREGIVER INFORMATION

Please include demographic information for any caregivers who will be attending group sessions. This information is requested for inclusion on grant applications and reports.

Gender

Caregiver Name	Female	Male	Trans-gender	Non-binary/ Non-conforming	Prefer to self-describe	Prefer not to respond

Race (Select one or more.)

Caregiver Name	White	Black	American Indian	Asian	Pacific Islander	Prefer to self-describe	Prefer not to respond

Ethnicity

Caregiver Name	Hispanic/Latino? Y or N