



# An Elderly Wish Foundation - Wish Request Form

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## HOW TO REQUEST A WISH

To help make your wish come true, we need a few things to get started. We ask that you take the following steps:

- Step 1: Write a paragraph explaining your wish.
- Step 2: Complete the Request Form.
- Step 3: Have your physician or medical care provider complete the Physician Statement;
- Step 4: Include a photo of yourself.

Use the attached forms. We will verify your eligibility, contact you with any questions, and get started on your wish.

**Once you have completed the four steps, send the completed application to:**

**An Elderly Wish Foundation**

**"Making Wishes Come True"**

**P.O. Box 4365, Antioch, CA 94531-4365**

**Telephone (925) 978-1883**

**FAX (925) 978-1884**

## WISH REQUEST LETTER OR FAX

As part of your wish request, we ask that you send us a personal note, written by you, or a close family member, describing your wish, why you need our help, and the importance or significance of the wish to you. We want you to tell us **WHY** this wish matters to you, and **HOW** this wish will provide you with a greater sense of comfort and fulfillment. Your letter or fax should:

- Refer to the illness you are battling
- Clearly describe what your special wish is
- If your wish involves air travel, include the airport of departure and desired dates for travel

Unfortunately, we cannot grant the following types of wishes:

- Requests for cash, automobiles, or property;
- Requests for foreign travel or visas
- Requests to pay for medical treatments or legal assistance



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## WISH REQUEST FORM

Please write legibly in ink.

Recipient's Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Age (60 & Over) \_\_\_\_\_ DOB \_\_\_\_\_

Referred by \_\_\_\_\_

I give permission to An Elderly Wish Foundation to contact my physician for verification of my illness on behalf of my wish.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Nearest Relative/Contact \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

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

Phone (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_



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### PHYSICIAN'S STATEMENT OF ELIGIBILITY

I certify that I am the wish Recipient's Primary Physician or Medical Care. I give permission for a wish to be granted to the individual named below, by the Board of Directors of An Elderly Wish Foundation. I understand that to be eligible for a wish the recipient must have been diagnosed with a terminal or life threatening disease.

Recipient's Name \_\_\_\_\_

Diagnosis \_\_\_\_\_

Is oxygen required for air travel? YES / NO

Physician or Medical Care Provider's Name: \_\_\_\_\_

Address \_\_\_\_\_

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

Phone ( \_\_\_\_ ) \_\_\_\_\_

Email \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_