# RESPITE HOUSING PATIENT APPLICATION

Please complete all sections of this form and return to:
Address: 6601 Frederick Road, Baltimore, Maryland 21228
Phone: 410.744.1032 Fax: 410.744.1984
Email: programs@believeintomorrow.org Website: www.believeintomorrow.org

## Part I (To be completed by parent/guardian) PLEASE PRINT CLEARLY

Patient's Name _____ Nickname _____

(First) (Middle Initial) (Last)

Date of Birth _____ Sex _____ Age _____

(month/day/year)

Home Address _____

(number/street address) (County)

City _____ State _____ Zip Code _____

Do both parents live at this address? □ yes □ no

If no, please provide the address of other home and who it belongs to below:

***Parent 1 (Primary Contact)***

Name: First _____ Last _____ Military □ Active

Parent 1's Occupation, Employer Name & Address:

Parent 1's Cell Phone: ( ) Parent 1's Work Phone: ( )

Paren 1's E-mail address:

***Parent 2***

Name: First _____ Last _____ Military □ Active

Parent 2's Occupation, Employer Name & Address:

Parent 2's Cell Phone: ( ) Parent 2's Work Phone: ( )

Parent 2's E-mail address:

Legal Guardians (if other than parents):

***(Note: We ask for name and contact information for both biological parents. If child is under the custody of one parent, please attach a copy or email a copy of the child custody order or both parents must sign all documents)***

**PLEASE PRINT CLEARLY**

Patient's Name

**Names and ages of all other children living at home:**

1. Name Birthdate Relationship

2. Name Birthdate Relationship

3. Name Birthdate Relationship

4. Name Birthdate Relationship

5. Name Birthdate Relationship

**Name, age and relationship of other person residing with child:**

Name Birthdate Relationship

Name Birthdate Relationship

**Hospital where child is being treated** **City** **State**

Attending Physician

Physician Phone #

**Please describe your child's illness and any special medical needs or considerations:**

(For example, the child is confined to a wheelchair, in need of 24-hour nursing care, in need of oxygen, etc.)

Has your child ever participated in any Believe In Tomorrow Programs? □ yes □ no

I understand and recognize that participation in any Believe In Tomorrow National Children's Foundation Program is contingent upon approval by the Believe In Tomorrow National Children's Foundation as well as compliance with all conditions, qualifications and restrictions designated by the Believe In Tomorrow National Children's Foundation.
***Note: Both parent signatures are required for approval.***

▶ **Parent/Guardian** **Date**

▶ **Parent/Guardian** **Date**

## LIABILITY RELEASE AUTHORIZATION DISCLOSURE

*Please read and complete all sections on reverse.*

As a requirement for participation in any Believe in Tomorrow™ National Children's Foundation program or service including, but not restricted to participation in the Children's Housing Programs-Hospital and Retreat Housing, The Believe In Tomorrow Children's House at Johns Hopkins and Hands On™ Adventures programs (hereafter, above list of programs simply referred to as "Believe In Tomorrow National Children's Foundation"), the parent(s) or legal guardian(s) must sign this Liability Release and Authorization to Disclose Information.

**Liability Release:** The undersigned both individually, jointly and on behalf of the child who is eligible to participate in Believe In Tomorrow National Children's Foundation Programs, understand that involvement in Believe In Tomorrow National Children's Foundation Programs may involve risk of injury or harm to the participant and that all risk is fully assumed by the undersigned. The undersigned both individually, jointly, and on behalf of the child who is eligible to participate in Believe In Tomorrow National Children's Foundation Programs, does hereby agree to release, forever discharge, and hold the Believe In Tomorrow National Children's Foundation, their directors, officers, employees, agents, volunteers, successors and assigns harmless from and against any and all actions, causes of action, liability, claims and demands for, any damages and claims of any kind whatsoever, whether known or unknown, in connection with or arising from any incident(s) or occurrence(s) during the child's participation or consideration of participation in Believe In Tomorrow National Children's Foundation Programs.

**Authorization To Disclose and Obtain Medical Information:** The parent(s) or legal guardian(s) give the Believe In Tomorrow National Children's Foundation authorization to obtain all medical information which the Believe In Tomorrow National Children's Foundation may feel is necessary for the consideration or participation in Believe In Tomorrow National Children's Foundation Programs. The parent(s) and legal guardian(s) authorize all of the child's physicians and medical care providers to provide the Believe In Tomorrow National Children's Foundation with all medical information regarding the child that is applying to participate in Believe In Tomorrow National Children's Foundation Programs.

**Authorization for Disclosure to Third Parties:** The parent(s) or legal guardian(s) understand and agree that Believe in Tomorrow National Children's Foundation may disclose their child's identifying information to a third party in order for the third party to provide notices to the parent(s) or legal guardian(s), such as when an event is cancelled.

**Authorization Regarding Publicity:** It is understood and agreed that participation in Believe In Tomorrow National Children's Foundation Programs may result in publicity that in order for the Believe In Tomorrow National Children's Foundation to continue its services, it is helpful to be able to portray children and families using programs in a positive way in brochures, newsletters, on Believe In Tomorrow National Children's Foundation Websites, and other promotional materials. The undersigned both individually and on behalf of the child who is eligible to participate in Believe In Tomorrow National Children's Foundation Programs authorize the Believe In Tomorrow National Children's Foundation to use the name of their child for publicity or promotional purposes.

**Authorization Regarding Photo:** Due to the nature of Believe In TomorrowTM National Children's Foundation's programs publicity is sometimes unavoidable. Although the Believe In Tomorrow National Children's Foundation cannot control outside media, the undersigned as the parent(s) or legal guardian(s) of the child, by checking below, may grant or deny permission for Believe In Tomorrow National Children's Foundation to use photographic images of their child and/or family in Believe In Tomorrow National Children's Foundation's promotional materials, such as brochures, newsletters, Websites, press releases, and any other means. The undersigned understand and agree that if they deny permission, Believe in Tomorrow National Children's Foundation will use its best efforts to prevent use of the photographic images but cannot make any guarantee with respect to publicity.

**(To be completed by patient's parent/guardian)**

****Place a check or X in the appropriate box:**

☐ **I GRANT** ☐ **I DENY** permission for the Believe In Tomorrow National Children's Foundation to use a photographic image of my child and/or family in Believe In Tomorrow National Children's Foundation promotional materials.

This Liability Release and Authorization to Disclose Information contains the entire agreement between the parent(s) or legal guardian(s) and the Believe In Tomorrow National Children's Foundation and that the terms hereof are contractual and not a mere recital. By signing below, the parent(s) or legal guardian(s) of the child acknowledge they have read, understand and consent to the terms set forth herein.

**PLEASE PRINT CLEARLY**

Patient's Name

Date of Birth

Diagnosis of Patient

Home Address

City State

County Zip Code

Cellphone ( )

E-mail

Patient's Facebook/Caringbridge site

**(If child has two parents or legal guardians, both parents or legal guardians must sign below.)**

▶ **Parent/Guardian** **Date**

▶ **Parent/Guardian** **Date**

**PLEASE PRINT CLEARLY**

Patient's Name

## PART II Medical Assessment: (To be completed by social worker or medical professional)

**Name of Healthcare Worker completing assessment:**

*Someone who can speak on behalf of how the family conducts themselves

Hospital

Phone E-mail

Diagnosis of Patient Date of Dx

Is this condition considered ☐ life threatening, ☐ life long, ☐ short life expectancy, ☐ chronic?

Is patient undergoing continued treatment for this illness? If so, how often and what treatment?

If treatment has ended, when was the last date of treatment?

How often is the patient seen by the doctor?

Date of Last Visit:

☐ I have discussed in detail the Believe In Tomorrow programs with BIT staff and fully understand the program (if not, please call our office)

☐ I have discussed in detail the Believe In Tomorrow programs with this family

**Based on my experience with this famlly...**

▶ **Healthcare Worker Signature** **Date**