



Respite House Application

ELIGIBILITY

Families that are battling a health crisis, whether it be cancer or other illness and are financially, physically and emotionally fatigued.

Your family has not traveled on a self funded vacation or a vacation through another nonprofit organization within the past year.

APPLICATION

In order to be considered for participation in our program the applicant/applicant's family must submit a completed application. All forms must be signed. The medical assessment **MUST** be filled out and signed by the physician.

Acceptance at the Healing Hearts Respite house is contingent upon receipt of all completed forms and approval by The Healing Hearts Respite Foundation. Guidelines and eligibility requirements must be followed.

The completed application is due no later than 2 weeks prior to the requested stay with a **\$100** deposit that will be held in escrow for any damages to Healing Hearts Respite House during the stay.

This amount will be returned once the guests leave and verification has been made that the house has not been damaged or suffered any lost items or equipment.

Accommodations are free of charge. Successful applicants will be required to enter a 'rental' agreement. Families must provide their own transportation to and from The Healing Hearts Respite House. Our first priority is families with the greatest need.

This is not a vacation home. This is a one time event to be shared with families who need to benefit from a time of respite with their family during their crisis. At the discretion of our board, we can extend a second visit to our Respite Home if there were a subsequent recurrence of illness or other hardship that may affect a family.

RESPIRE HOUSING ELIGIBILITY REQUIREMENTS

A qualified applicant/family member must have the Medical Assessment form filled out and signed by a physician for the family member with the illness stating that it is ok for them to travel.

The family must provide their own transportation to and from the Healing Hearts Respite House.

The family must be able to provide their own meals.

The family must be respectful and responsible, with no indication of inability to abide by rules/regulations.

PETS: No Pets Allowed, unless a trained service dog is required for the patient. Please advise Healing Hearts Respite Foundation if a service dog will be assisting the patient during their stay. Please visit our website regarding more information on service dogs.

FAMILY APPLICATION

Healing Hearts Respite Foundations offers the house to families that are battling a health crisis, whether it be cancer or other illness and are financially, physically and emotionally fatigued. Our home is designed to bring comfort, joy and hope to families enabling them to renew their spirits mentally and physically.

Family Information:

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Email Address: _____

Family Member with Disability/Illness:

Name: _____

Address: _____

Date of Birth: _____

Name and ages of all persons that will be staying at the Healing Hearts Respite House:

1. Name	Birthdate	Relationship
2. Name	Birthdate	Relationship
3. Name	Birthdate	Relationship
4. Name	Birthdate	Relationship
5. Name	Birthdate	Relationship
6. Name	Birthdate	Relationship
7. Name	Birthdate	Relationship
8. Name	Birthdate	Relationship
9. Name	Birthdate	Relationship
10. Name	Birthdate	Relationship

Healing Hearts Respite House is not handicap accessible and does not have an elevator.
We do not offer nursing care or any hospital equipment i.e. oxygen, etc.)

I/We understand and recognize that participation at the Healing Hearts Respite House is contingent upon approval by The Healing Hearts Respite Foundation, as well as compliance with all conditions, qualifications and restrictions designated by The Healing Hearts Respite Foundation.

Signature of Applicant

Date

LIABILITY RELEASE AUTHORIZATION DISCLOSURE

As a requirement for participation at the Healing Hearts Respite House in Corolla, NC located in the Currituck Club, the following must be completed in full by the primary adult staying at the respite home.

Liability Release: The undersigned individually, jointly and on behalf of the patient, and other guests during the patient's stay (the "participants"), understands that involvement in the Healing Hearts Respite House may involve risk of injury or harm to the participants and that all risk is fully assumed by the undersigned. The undersigned both individually, jointly, and on behalf of the patient and the participants, does hereby agree to release, forever discharge, and hold The Healing Hearts Respite 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 patient's and participants' participation or consideration of participation at the Healing Hearts Respite House.

Authorization to Disclose and Obtain Medical Information: The patient, or parent(s) or legal guardian(s) give The Healing Hearts Respite Foundation authorization to obtain all medical information which The Healing Hearts Respite Foundation may feel is necessary for the consideration or participation at The Healing hearts Respite House. The patient or parent(s) and legal guardian(s) authorize all of the patient's physicians and medical care providers to provide The Healing Hearts Respite Foundation with all medical information regarding the patient that is applying to participate at the Healing Hearts Respite House.

Authorization for Disclosure to Third Parties: The patient or parent(s) or legal guardian(s) understand and agree that The Healing Hearts Respite Foundation may disclose their patient'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 some unforeseen issue occurs whereby we need to cancel (i.e. weather, etc.).

Authorization Regarding Publicity: It is understood and agreed that participation in Healing Hearts Respite Foundation may result in publicity, and that in order for Healing Hearts Respite Foundation to continue its services, it is helpful to be able to portray patients and families using Healing Hearts Respite house in a positive way in brochures, newsletters, on Healing Hearts Respite Foundation Websites, and other promotional materials. The undersigned both individually and on behalf of the patient and participants authorize Healing Hearts Respite Foundation to use the name of the patient/family for publicity or promotional purposes.

Authorization Regarding Photo: Due to the nature of Healing Hearts Respite Foundation, publicity is sometimes unavoidable. Although Healing Hearts Respite Foundation cannot control outside media, the undersigned as the patient, parent(s) or legal guardian(s) of the patient, by checking below, may grant or deny permission for Healing Hearts Respite

Foundation to use photographic images of the patient and/or family and participants in Healing Hearts Respite Foundation promotional materials, such as brochures, newsletters, Websites, press releases, and any other means.

The undersigned understand and agree that if they deny permission, Healing Hearts Respite Foundation will use its best efforts to prevent use of the photographic images but cannot make any guarantee with respect to publicity.

Please complete and sign below. Please place a check or X in the appropriate blank.

I GRANT

I DENY

permission for Healing Hearts Respite Foundation to use a photographic image of the patient and/or family and participants in promotional materials.

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

Patient's Name _____

Date of Birth _____

Diagnosis of Patient _____

Home Address _____

City _____ State _____

Zip _____

Home Phone Work Phone Cell phone E-mail (If a child has two parents or legal guardians, both parents and legal guardians must sign below.) Parent/Guardian
Date Parent/Guardian Date Witness Date

CHOICE OF DATES

Guests can choose a long weekend Friday - Tuesday , check in at 3:00 p.m. Friday and check out by 10:00 a.m. Tuesday or

Friday – Friday (Full Week) Check In - 3:00 p.m. Check Out - 10:00 a.m. Please provide

us with your dates of choice: (i.e. calendar date and day of the week)

1st choice: 2nd choice: 3rd choice: Dates are subject to first come first served basis or the family with the greatest need.

We cannot confirm your dates until the application process has been approved and the refundable deposit of

\$100 is secured.

Please complete all sections of this form and return to:

Healing Hearts Respite Foundation

PO Box 168, Haymarket, VA 20168

Or: email to ksproles@healingheartsrespitfoundation.org

Medical Waiver

Medical Assessment: (To be completed by physicians)
Name of physician completing assessment (Please Print)

Name of Family member with illness or disability _____

Hospital _____ City _____ St _____

Phone/Fax _____ / _____

Diagnosis _____ Date of Diagnosis _____

Is this condition considered ___ life threatening, ___ life long, ___ short life expectancy?

Is the patient undergoing continued treatment? ___ If so, how often?

What treatment is the patient undergoing?

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 (the physician) have explained the applicant/patient's medical condition to the family and have instructed them on how to handle some medical emergencies. As long as the family takes sufficient precaution to protect the applicant/patient in accordance with the physician's instruction, there is no medical constraints to applicant/patient's participation at the Healing Hearts Respite Foundation House.

Physician's Signature _____ Date _____



House Rules

1. Please treat the house and all its contents with kindness so that other families may enjoy their stay.

2. No Pets unless prior notice was given to Healing Hearts Respite Foundation for trained service dog to assist patient.
3. Please DO NOT move any furniture.
4. No Smoking inside the house.
5. Clean out refrigerator/freezer – Please do not leave any food behind. Empty all trash. Do not leave food in the pantry.
6. Put all sheets and towels back into the black bins outside.
7. Please do not take any dishes, linens or furnishings home with you
8. Bed Spreads - blankets are provided for each bed. Please fold down the decorative bedding and use the blankets provided.
9. Grill – A grill is provided for your use. Please clean it after each use. Pull grill away from deck railing or house siding while in use to avoid fire hazard.
10. Pool and Hot Tub – are provided for your use. Please use pool and spa safely. Pool is small, No Diving Allowed.
11. Parking – the driveway will comfortably hold 3 vehicles. DO NOT park in garage or on the grass. Parking is not allowed on the street. There is overflow parking available at the fitness center, please check in with them if you are going to park there.
12. Make unforgettable memories and enjoy your time of respite

Applicant Signature

Date