FAMILY LIVES ON FOUNDATION$_{SM}$ APPLICATION FOR SERVICES

Mommy's Light® Daddy's Light$_{SM}$

Dear Prospective Family,

Thank you for your interest in Family Lives On Foundation$_{SM,}$ home of Mommy's Light® and Daddy's Light$_{SM}$. Enclosed you will find an Application for Services, which must be completed and returned to Family Lives On Foundation$_{SM}$ by mail: P.O. BOX 494, Lionville, PA 19353 OR fax: 610-458-1691.

If you have any questions about this application, or about Family Lives On Foundation$_{SM}$ services, please contact our offices at 610-458-1690 and we would be happy to assist you.

Warm Regards,

Family Lives On Foundation$_{SM}$

HOW DID YOU HEAR ABOUT US?

___ WEB SEARCH ___ MEDIA ___EVENT ___CHURCH ___SOCIAL WORKER ___HOSPICE

___ SCHOOL COUNSELOR ___FAMILY THERAPIST ___WORD OF MOUTH ___OTHER

Details:_____

_____

_____

ELIGIBILITY DETERMINATION:

In order to be eligible for services from Family Lives On Foundation$_{SM}$ the young person's mother or father must have a life-threatening illness or be deceased. If the mother or father has a life threatening illness, please complete Sections A & C, as well as Attachment A. If the mother or father is deceased, please complete Sections B & C.

Ill or Deceased Parent Name:_____ Gender: _____

Section A – The parent has a life-threatening illness:

Parent's Primary Doctor:_____ Phone:_____

Address:_____ Fax:_____

Parent's medical diagnosis:_____

Section B – The parent is deceased:

Date of Death:_____ Circumstances of Death:_____

Please attach evidence of death (i.e., a copy of the death certificate, copy of obituary)

Section C – Child(ren) & Family Information:

CHILDREN:

Name	Gen	DOB	Age	School	SSN

PARENT/GUARDIAN 1:

Name:				**Relation to child:**	
Address:					
Home Phone:		**Cell Phone:**		**Work Phone:**	
E-Mail:			**Employer:**		
Best way to reach you:			**Best time to reach you:**		

PARENT/GUARDIAN 2: (if applicable)

Name:				**Relation to child:**	
Address:					
Home Phone:		**Cell Phone:**		**Work Phone:**	
E-Mail:			**Employer:**		
Best way to reach you:			**Best time to reach you:**		

Other children or adults living in the primary residence:

Name	DOB	Relation to Child(ren)

Parent/Guardian 1 Signature:_____ Date:_____

Parent/Guardian 2 Signature:_____ Date:_____

ATTACHMENT A

AUTHORIZATION OF MEDICAL INFORMATION RELEASE:

I, _____, hereby authorize Family Lives On Foundation$_{SM}$ (FLOF) to contact my physician regarding the nature of my illness in order to determine whether my child(ren) are eligible to receive Tradition Fulfillment$_{SM}$ services from FLOF. I also authorize my physician to complete the FLOF medical authorization form.

I understand that while I am still living, FLOF will need to contact my physician every 2 years regarding the nature of my illness in order to determine if my child(ren) are still eligible to receive Tradition Fulfillment$_{SM}$ services from FLOF. I will be notified by FLOF before my physician is contacted.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV-RELATED INFORMATION: (if applicable)

HIV related information is information which concerns whether a client/patient has been tested for HIV, whether a client/patient has been diagnosed with AIDS or an HIV related illness, or could reasonably identify the client/patient as having one or more of these conditions.

I, _____, authorize Family Lives On Foundation$_{SM}$ (FLOF) to release my personal HIV related information at their own discretion to any and all individual(s) that will be involved in any capacity with fulfilling my child(ren)'s tradition request.

I fully understand that I have the right to revoke this authorization at any time. I also understand that my withdrawal of consent will only apply to situations occurring after the act of withdrawal and will not apply to any information previously released by FLOF in accordance with my original authorization.

This consent will expire two years from the date of signing. I will be notified by FLOF should my consent require renewal.

I have read and fully understand the above statements as they apply to me. I give FLOF full permission to release my personal HIV related information at their own discretion to any and all individuals involved in any capacity with fulfilling my child(ren)'s tradition request.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____