Application for Services

All sections must be completed to receive full consideration

Mother's General Information

Full Name: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____

Alternate Phone: _____ Type: ☐ cell ☐ work

Email: _____

Age: _____ Date of Birth: _____ Marital Status: ☐ married ☐ single

Father's Information

Full Name: _____

Street Address: _____

City:_____ State: _____ Zip: _____

Home Phone: _____

Alternate Phone: _____ Type: ☐ cell ☐ work

Email: _____

Age: _____ Date of Birth: _____ Marital Status: ☐ married ☐ single

Who is the patient? ☐ mother ☐ father

Diagnosed Illness: _____

Medical Considerations: ☐ wheelchair ☐ oxygen ☐ other

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY THE PATIENT

Power of Attorney

Do you have a Power of Attorney? ☐ yes ☐ no

Are they currently acting on your behalf? ☐ yes ☐ no

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Alternate Phone: _____ Type: ☐ cell ☐ work

Email: _____

Age: _____ Date of Birth: _____

Family Information

Number of dependent children (under the age of 18): _____

Total Number of children: _____

Names and ages of children:

_____

_____

_____

_____

_____

_____

Do the listed children reside with both biological parents? ☐ yes ☐ no*

Explain: _____

Additional Information:

Please explain your children's understanding of your diagnosis.

Please tell us why establishing your legacy is important to you.

Please explain your prognosis as you understand it.

REQUIRED SIGNATURES

I understand and agree:

1) That no promises or assurances whatsoever have been made to me by any representative of the *Let There Be Mom* organization regarding providing any services to me or my family;

2) That granting services of any kind is contingent upon approval by the *Let There Be Mom organization* and my physician, as well as full compliance with all conditions, qualifications, and restrictions designated by the *Let There Be Mom organization*;

3) That all individuals with parental or custodial rights for the children must approve participation with the *Let There Be Mom organization* and sign all necessary documents before services can begin; and

4) That full disclosure of anyone having power-of-attorney over me must be made and they must complete the appropriate documents before the *Let There Be Mom organization* will consider offering services to me.

I promise that the information provided by me is true and complete to the best of my knowledge.

_____ _____
Patient's Signature Date Power of Attorney Signature Date

_____ _____
Please Print Name Please Print Name

_____
Mother's Signature Date

_____
Please Print Name

Let There Be MOM

Hold Harmless Statement

I, the undersigned, agree to indemnify, protect and hold harmless *Let There Be Mom Inc* & its volunteers from all judgment, cost, claim for loss, damage or injury arising during my involvement with *Let There Be Mom Inc.*

(Please Print)
Let There Be Mom Applicant: _____

Address: _____

City: _____ State:_____ Zip:_____

Applicant's Signature: _____

Date:_____

Let There Be Mom Inc
Representative's Signature:_____

Date:_____

Let There Be MOM

Authorization For Use/Disclosure of Protected Health Information

To: _____("Physician") _____ _____ *(Physician's name and address)*	From: _____("Patient") _____ _____ *(Patient's name and date of birth)*

I authorize the use and disclosure to ***Let There Be Mom Inc***® ("***Let There Be Mom***") of protected health information about Patient, as described below.

1. Information that may be used/disclosed: All protected health information relating to Physician's assessments of whether Patient is medically eligible for ***Let There Be Mom's*** services. In addition, Physician is authorized to fill out, sign and provide to ***Let There Be Mom*** any forms that Let There Be Mom may require, including forms relating to Patient's medical eligibility, the requested services and medical considerations relating thereto.

2. Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives.

3. Persons authorized to receive the information: Employees or other authorized representatives of:
Let There Be Mom Inc Phone: (864)-608-9819 Fax: (864)234-7781

4. Purpose for which information will be used/disclosed: To enable ***Let There Be Mom*** to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to receive services from ***Let There Be Mom*** and, if so, whether the requested services are medically appropriate; and (b) pertinent information relating thereto.

5. Expiration date/event: This authorization expires once Patient has completed services with ***Let There Be Mom***, or a final determination has been made that Patient is not medically eligible to receive services.

6. Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

   A. I understand that I may revoke this authorization at any time by so notifying you in writing, except to the extent that action has already been taken in reliance on the authorization;

   B. I understand that I may refuse to sign this authorization and that my refusal to do so will not affect Patient's ability to obtain treatment or payment or eligibility for benefits; and

   C. I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

_____ _____
(Patient's representative) *(Signature of Patient)*

Date: _____

Let There Be MOM

Publicity Release

***Let There Be Mom* would appreciate your permission to use your story and/or photo in one or more of the media listed below. Please check all the boxes that are acceptable to you. It is very helpful to *Let There Be Mom* to be able to share the stories of the Moms we help. Awareness of our organization is crucial to our ability to help you and other families in similar situations. Please know that *Let There Be Mom* does its best to honor all requests, however participation as a *Let There Be Mom* family may result in publicity, whether or not *Let There Be Mom* actively takes any steps to publicize our services to you.**

Let There Be Mom Applicant: _____

Address: _____

City: _____ State:_____ Zip:_____

Please check the box next to all media that is acceptable:

- ☐ Local Newspaper, Radio, TV
- ☐ State and National Newspaper, Radio and TV
- ☐ *Let There Be Mom* Newsletter
- ☐ *Let There Be Mom* Website
- ☐ *Let There Be Mom* Direct Mail
- ☐ All of the Above
- ☐ Please do not use my story and/or photo in any of the above media.

Applicant's signature: _____ Date:_____

Power of Attorney's signature: _____Date:_____

Physician's Statement

Let There Be Mom Applicant: _____

D.O.B.: _____

Address: _____

City: _____ State:_____ Zip:_____

My signature certifies that I am the treating physician of the ***Let There Be Mom*** applicant named above. The applicant is of sound mental capability to sign legal documents. I understand that to be eligible for services from the ***Let There Be Mom*** Organization the applicant must have been diagnosed with a life threatening condition as defined by me, the treating physician. I believe that if the above named patient (applicant) were to refuse medical treatment, their life expectancy would be two years or less.

Physician's Signature: _____

Physician's Name: _____

Group Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____