H.O.P.E. Haven
Multi-Family
Vacation from Cancer Retreat
Respite Housing Application

ELIGIBILITY
The applicant (adult/child) must be undergoing active treatment for cancer. We consider treatment “active” when the applicant is seeing their physician for medication and/or therapy. An applicant is eligible until he/she has been off active treatment for one year.

It is our goal to offer cancer patients a 3 to 5 day stay in relaxing country setting of York County.

APPLICATION
To be considered for participation in our program the applicant/applicant’s family must submit a completed application. All forms must be signed or, if a child, then BOTH parents/guardians must sign.

Acceptance at H.O.P.E. Haven is contingent upon receipt of all completed forms and approval by The H.O.P.E. Haven committee, said approval at the complete discretion of the committee. Guidelines and eligibility requirements must be followed.

The completed application is due preferably 4 weeks prior to the requested stay with $25 nonrefundable application fee. Fee can be paid with a check, money order or PayPal.

Accommodations are free of charge.

Successful applicants will be required to enter a “rental” agreement.

Our priority is families with the greatest need.

RESPITE HOUSING ELIGIBILITY REQUIREMENTS
A qualified applicant must be in active treatment and being seen by a doctor monthly or more frequently. Active treatment often includes chemotherapy, radiation, BMT. An applicant remains eligible until he or she has been off active treatment for one year.

The family must be able to provide their own transportation to and from The Haven.
The family must be able to provide their own meals.
The family must be respectful and responsible, with no indication if inability to abide by rules/regulations.

PATIENT APPLICATION
The H.O.P.E. Haven offers a 3 to 5 days stay for families with cancer. Our unique multi-family-housing is designed to bring comfort, joy, and hope to patients and their families enabling them to renew their spirits mentally and physically.

Part I (To be completed by an adult patient or by parent/guardian if child is the recipient.)

Patient's Name

_____ _____ _____
First Middle Last

Home Address

Street Address/P.O. Box _____

County_____ City _____ State ____ Zip _____

Phone:_____ Cell: _____ Sex: _____
May we leave a message on Cell? Y◯N◯ May we send a text on Cell? Y◯N◯

Email: _____

Date of Birth: _____ Age: _____

Employer: _____

Phone & Address: _____

If patient is under 21:

Mother's Name: First_____ Last _____

Employer: _____

Phone & Address: _____

Mother's email: _____

Father's Name: First _____ Last _____

Employer: _____

Phone & Address: _____

Father's email: _____

Legal Guardians (if other than parents):

_____

Address: _____

Email: _____

Employer:_____

Phone & Address: _____

NOTE: If a child is under the custody of one parent or guardian, please attach a copy of the child custody order or both parents or guardians must sign all documents. Parents, in a divorced or separated situation, must both agree to share the opportunities that our program provides. If parents are not able to do so, we will work with the parent who has legal custody of the child. **A copy of the court ordered custody agreement will be required with application.**

Names and ages of all persons that will also be attending The Haven. Attach additional sheet if needed. The H.O.P.E. Haven has accommodations for no more than 10 guests at one time.

1. Name _____ Birthday: _____

    Relationship to patient: _____

2. Name _____ Birthday: _____

    Relationship to patient: _____

3. Name _____ Birthday: _____

    Relationship to patient: _____

4. Name _____ Birthday: _____

    Relationship to patient: _____

5. Name _____ Birthday: _____

    Relationship to patient: _____

Hospital where patient is being treated:

Name: _____ Street: _____

City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Please describe the type of cancer and any special medical needs or considerations:

_____

_____

_____

The H.O.P.E. Haven is ADA compliant. We do not offer nursing care or any hospital equipment.

I/We understand and recognize that participation at H.O.P.E. Haven is contingent upon approval by the H.O.P.E. Haven Committee, as well as compliance with all conditions, qualifications and restrictions designated by the H.O.P.E. Haven Committee.

Patient _____ Date _____

Parent/Guardian_____ Date _____

Parent/Guardian_____ Date _____

LIABILITY RELEASE
AUTHORIZATION DISCLOSURE

As a requirement for residency and participation at the H.O.P.E. Haven the following must be completed in full by all adults and for any minor by a responsible adult staying at the H.O.P.E. Haven.

Liability Release: The undersigned individually, and if executing this Release on behalf of a minor participants (hereinafter "Participant"), understands that residency and participation at the H.O.P.E. Haven may involve risk of injury or harm to the Participant and that all risk is fully assumed by the undersigned. The undersigned both Participants, does hereby agree to release, forever discharge, and hold Help for Oncology Problems and Emotional Support (hereinafter "H.O.P.E."), and its 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 Participant's residency and participation or at the H.O.P.E. Haven.

Authorization to Disclose and Obtain Medical Information: The Participant gives the H.O.P.E. authorization to obtain all medical information which H.O.P.E. may feel is necessary for the consideration or participation at H.O.P.E. Participant authorizes all the patient's physicians and medical care providers to provide H.O.P.E. with all medical information regarding the patient that is applying to participate at H.O.P.E. Haven.

Authorization for Disclosure to Third Parties: The Participant understand and agrees that H.O.P.E. 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 residency and participation at H.O.P.E. may result in publicity, and that for H.O.P.E. to continue its services, it is helpful to be able to portray patients and families using H.O.P.E. in a positive way in brochures, newsletters, on the H.O.P.E. websites, and other promotional materials. The undersigned both individually and on behalf of the patient and Participants authorize H.O.P.E. to use the name of the patient/family for publicity or promotional purposes.

Authorization Regarding Photo: Due to the nature of the H.O.P.E. Haven, publicity is sometimes unavoidable. Although H.O.P.E. 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 H.O.P.E. to use photographic images of the patient and/or family and participations at H.O.P.E.'s promotional materials, such as brochures, newsletters, websites, press releases, and any other means.

The undersigned Participant understands and agrees that if they deny permission, H.O.P.E. 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 H.O.P.E. to use a photographic image of the patient and/or family and Participant in promotional materials.

This Liability Release and Authorization to Disclose Information contains the entire agreement between the Participant and H.O.P.E. and that the terms hereof are contractual and not a mere recital. By signing below, Participant acknowledges they have read, understand and consent to the terms set forth herein.

Participant's Name _____

Date of Birth _____

Diagnosis of Patient _____

Home Address _____

City _____ State _____ Zip _____

_____ _____ _____

Home Phone Work Phone Cell Phone

Email _____

Emergency Contact Name _____

Emergency Phone _____ Relationship _____

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

Parent/Guardian _____ Date _____

Parent/Guardian _____ Date _____

Witness _____ Date _____

No pets allowed unless medical aid approved. Certification of such must accompany this application.

CHOICE OF DATES

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

1st Choice _____

2nd Choice _____

3rd Choice _____

Dates are subject to first come first serve basis.

We cannot confirm your dates until the application process has been approved.

Would you be interested in a last-minute call if we have a cancelation? ◯ Y or ◯ N

DIETARY REGULATIONS

Do you or anyone in your party have any food allergies? ◯ Y or ◯ N

If so, please explain further

_____

_____

Are you or anyone in your party gluten free? ◯ Y or N ◯

Are you or anyone in your party dairy free? ◯ Y or N ◯

Will you or anyone in your party bring medications with you? ◯ Y or N ◯

Will you or anyone in your party need to refrigerate medications? ◯ Y or N ◯

Please complete all sections of this form and return to:

H.O.P.E. Haven
P.O. Box 279
Stewartstown, PA 17363

NOTE: Oxygen tanks are not allowed in the H.O.P.E. Haven

H.O.P.E. Haven Rules

Please note the following:

No more than 10 overnight guests are allowed at any one time at the H.O.P.E. Haven. Parking is limited to no more than 2 vehicles per family.

3 Suites – each with 2 bedrooms and 1 bath

Handicap accommodations – Large bathroom, 1 bedroom, 1 sitting room with day bed

All linens and bath towels are provided.

During your stay please abide by the house rules as detailed below.

The H.O.P.E. Haven **DOES NOT** allow the following in the house or on the property:

Smoking	Motor homes, campers, tents, etc.
Pets	Potted Plants/Flowers
Skateboards	Campfires other than the designated area

On check-out day please take care of the following:

Leave the H.O.P.E. Haven key on kitchen counter.

Put your sheets and towels in the laundry room in clear bags.

Empty all trash cans and take outside and place where indicated.

I/We agree to abide by the rules of the H.O.P.E. Haven and any violation of the above will result in forfeiture of my/our deposit and/or the reminder of my/our stay.

Name _____ Date _____

~ The visit to H.O.P.E. Haven is terminated if the patient is unable to attend.

~ Any violators of the H.O.P.E. Haven Rules will result in being asked to leave the premises and will not be eligible for any future stays.

~ If you cancel less than one month before your stay is scheduled to begin, you will be able to reschedule your visit.

We thank you for taking good care of H.O.P.E. Haven!