brent's place

for our kids with cancer — a home for families

Hello!

Thanks for taking the time to fill out your application to Brent's Place. This information is important so we can know best how to help you while you are here and so you know our expectations as well. Please include everything on this check list to make sure that we are ready for you when you arrive:

- ☐ Completed Intake Application
- ☐ Completed and Signed HIPPA Form
- ☐ Completed and Signed Insurance Authorization Form
- ☐ Copy of Insurance/Medicaid Card (**Front and Back**)

***Our Family Benefits Coordinator will contact you on receipt of this application to work with you on your insurance and lodging benefits. This call will not guarantee that housing is available, but is part of our pre-authorization process.**

If you have any questions or concerns, please call us at 720-343-2800 and ask for a Family Services Manager. We are happy to help.

We look forward to helping you while you are in Colorado!

~ The Brent's Place Staff

INTAKE INFORMATION
16th Street, Aurora
Fax: 303-831-4567

brent's place
for our kids with cancer — a home for families

Date: _____

Personal Information

Patient's Name: _____ Gender: _____ Date of Birth: ____/____/____

Permanent Address: _____

City: _____ State: _____ Zip: _____ Patient's Cell phone: _____

Patient Web Page and/or Email: _____

Caregiver (CG) #1 Name: _____ Relationship to patient: _____

CG #1 Address: _____ □ same as patient address

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

Permanent Phone: _____ Cell phone: _____ E-mail address: _____

Caregiver (CG) #2 Name: _____ Relationship to patient: _____

CG #2 Address: _____ □ same as patient address

City: _____ State: _____ Zip: _____ Date of Birth: ____/____/____

Permanent Phone: _____ Cell phone: _____ E-mail address: _____

Other Children/Sibling Names:	**Gender:**	**Date of Birth:**	**Will they be staying with you?**

Vehicle Information:

Primary Car: Make _____ Model _____ Color _____ License Number _____

Secondary Car: Make _____ Model _____ Color _____ License Number _____

Emergency Contact:

Name: _____ Phone: _____ Cell: _____ Relationship to Patient: _____

Patient's Favorites:

Color: _____ Food: _____ Movie: _____

Cartoon: _____ Game: _____ Sport: _____

Animal: _____ Activity outside the house: _____

What do you like to do in your spare time? _____

What kind of crafts do you like to do? _____

Brent's Place Family T-shirts:
Please provide us with t-shirt sizes for each family member staying at Brent's Place. We have shirts available for babies, toddlers, children and adults. Adult shirts are unisex and come in sizes S-3XL.

Patient: _____ Caregiver 1: _____ Caregiver 2: _____

Sibling: _____ Sibling: _____ Sibling: _____ Sibling: _____

Other: _____

In order to help us understand how we can best support you during your stay here, please answer the following questions:

1. On a scale of 1-10 (1 being "not at all" and 10 being "fully") how financially supported do you currently feel?
   1 2 3 4 5 6 7 8 9 10

2. On a scale of 1-10 (1 being "not at all" and 10 being "fully") how emotionally supported do you currently feel?
   1 2 3 4 5 6 7 8 9 10

Hospital Information

Hospital Name: _____ Doctor: _____ Social Worker: _____

Please describe the patient's illness and treatment plan:
Diagnosis: _____

_____

Transplant (Please circle) BMT Auto Allo – Donor: _____ Organ: _____ Date: _____

Treatment (Please circle) Chemo Timeframe: _____ Radiation Timeframe: _____

Demographic Information

Provision of the following information is strictly voluntary. This information will be used for the purpose of fundraising for Brent's Place and will always be used anonymously. Thank you for your input.

Ethnicity

☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian or Pacific Islander ☐ Middle Eastern

☐ Native American / Alaskan Native ☐ Multi-Racial ☐ Other _____

Annual Household Income:

☐ Less than $10,000 ☐ 10,000 – 20,000 ☐ 20,000 – 30,000 ☐ 30,000 – 40,000 ☐ 40,000 – 50,000

☐ 50,000 – 60,000 ☐ 60,000 – 70,000 ☐ 70,000 – 80,000 ☐ 80,000 – 90,000 ☐ 90,000 or more

Housing:
☐ Rent ☐ Own

Distance Traveled:
☐ Less than 50 Miles ☐ 50 – 100 Miles ☐ 100 - 150 Miles ☐ 150 Miles or more

Public Assistance

☐ Patient -- SSDI ☐ Patient -- SSI ☐ Patient -- Medicaid ☐ Patient -- Medicare

☐ Caregiver -- SSDI ☐ Caregiver -- SSI ☐ Caregiver -- Medicaid ☐ Caregiver – Medicare

AUTHORIZATION TO PARTICIPATE AND RELEASE OF CLAIMS

I, _____ understand that my occupancy of a Brent's Place®
Name of Parent/Caregiver

apartment is provided by the Brent Eley Foundation as a service to the patient _____ and
Name of Patient

me during the course of the patient's medical care. I assume full and complete responsibility for any injury, accident or unusual occurrence that may occur to the patient or me during my stay here.

I also understand and agree to permit the staff of Brent's Place ® to use for publicity or promotional purposes, my name and pictures, videotapes or other recordings of me, or the patient without liability or obligation to me.

I authorize the minor child (children) named below to participate in on and off campus activities and events.

I UNDERSTAND AND ASSUME THE RISKS OF THE IN-HOUSE AND OFF CAMPUS ACTIVITIES OFFERED, INCLUDING BUT NOT LIMITED TO THE RISK OF INJURIES OF DEATH FROM A MOTOR VEHICLE ACCIDENT WHICH OCCURS WHILE ANY MEMBER OF MY FAMILY IS RIDING IN A VEHICLE OWNED OR OPERATED BY A BRENT'S PLACE EMPLOYEE OR VOLUNTEER . UNDERSTANDING THOSE RISKS, AND IN CONSIDERATION OF THE BENEFITS PROVIDED TO ME AND MY FAMILY MEMBERS FROM SUCH ACTIVITIES, I HEREBY ADVISE, REPRESENT AND WARRANT TO THE BRENT ELEY FOUNDATION THAT I DO HEREBY RELEASE THE FOUNDATION, ITS OFFICERS, DIRECTORS, SHAREHOLDERS, EMPLOYEES AND ANYONE ELSE DIRECTLY OR INDIRECTLY CONNECTED WITH THE FOUNDATION FROM ANY LIABILITY IN THE EVENT OF ANY INJURY OR DAMAGE OF ANY NATURE (OR PERHAPS EVEN DEATH) TO ME, A FAMILY MEMBER OR ANYONE ELSES WHICH OCCURS DURING PARTICIPATION IN ONE OR MORE OF THE OUTINGS OR ACTIVITIES, OR THE TRANSPORTATION RELATING TO SUCH OUTINGS OR ACTIVITIES.

I have executed this release willingly and understand that by signing this release I give up any right I may have to sue or make any claim or demand on my behalf or on behalf of any family member for any injuries related to or in any way connected with participating in any of the activities me or my family engage in or during the course of residency at Brent's Place. I understand and intend that this release covers all injuries, even if such injuries are a result of the negligence of The Foundation or any person associated with The Foundation. This authorization and release constitutes the entire agreement between The Brent Eley Foundation and myself regarding the subjects addressed in this document.

I further consent to and authorize the release by the hospital treating the patient named above, of general information relating to the patient, our family background, and the medical situation which has brought us to Brent's Place®. To the extent that any of such information becomes public, I release the Brent Eley Foundation, its officers, directors, employees and volunteers from any cause of action which I may have, or my family may have, including but not limited to statutory and common law rights of action relating to confidentiality and privacy. I also release the hospital providing such information to Brent's Place® or to the Brent Eley Foundation, from any claim I may have under The Health Insurance Portability and Accountability Act (HIPAA), and any and all regulations promulgated thereunder. I understand that the release of the general information described above will assist Brent's Place®, their employees and volunteers, in providing service to my family. I also understand that if I do not want my family to appear in photographs or promotional materials which Brent's Place® may distribute, I will so inform Brent's Place® of this in writing.

By my signature below, I hereby certify that I have read and understand the entire document.

Name of patient: _____ Name of child/sibling #2: _____

Name of child/sibling #3: _____ Name of child/sibling #4: _____

Name of any other participating party/visitors: _____

Signature of parent/caregiver #1: _____ Date: _____

Signature of parent/caregiver #2: _____ Date: _____

Occupancy Information and Agreement

- **Please notify staff immediately of any maintenance issues, emergencies, and/or alarming situations.** For example: Laundry Machine malfunctions, light bulbs out, alarming smell (smoke), unfamiliar people in or around building, issues with other tenants.
- **Resident mail should be sent to C/O Brent's Place, Attn: (Your Name), 11980 East 16th Avenue Aurora, CO 80010.** DO NOT CHANGE your address on a permanent basis. Mail can be collected from the Family Mailboxes behind the reception desk.
- **We allow one car in the garage per apartment.** Additional vehicles may park along the east side of the building.
- **Due to HIPPA, Brent's Place staff is not able to comment on the health status of any of our residents.**

Safety and Security Rules and Guidelines

- The following rules have been developed for the safety and security of all families and staff at Brent's Place, and are taken very seriously.
- Failure to comply with these rules can and will result in you being asked to leave Brent's Place immediately and permanently.

No Smoking on Brent's Place Property. This include apartments, laundry rooms, hallways, elevators, stairwells, balconies, porches, etc. There is zero tolerance for failure to comply with the NO SMOKING policy. **The only designated smoking area is outside on the east side of the building by the fenced-in dumpsters.**

I read and understand this rule and will follow it. _____

All illegal drugs, drug use and drug paraphernalia are strictly prohibited on the Brent's Place Property. Any indication of drugs, drug use and drug paraphernalia will result in immediate expulsion and possible notification of authorities.

I read and understand this rule and will follow it. _____

All firearms, ammunition, and explosives are strictly prohibited from Brent's Place Property. Any indication of firearms, ammunition, and explosives will result in immediate expulsion and possible notification of authorities.

I read and understand this rule and will follow it. _____

Doors to all buildings and apartments must be shut and locked at all times. Please no not prop doors and leave them unattended. This is a security risk and your health and safety is our top priority.

I read and understand this rule and will follow it. _____

You are responsible for the behavior of your guests while at Brent's Place. If guests of yours violate our rules & policies during their visit to Brent's Place, your stay with us might be compromised. Please ensure all guests know, understand, and follow our rules.

I read and understand this rule and will follow it. _____

Apartment/Facility Rules and Guidelines

An adult caregiver must be living with the patient at all times. Under no circumstances should the patient be left alone without a caregiver. **Please notify staff if there is a change of caregivers**. New caregivers must sign and understand occupancy agreement and cleaning guidelines.

I read and understand this rule and will follow it. _____

Brent's Place employees may enter the apartment at any time. They will enter for maintenance and/or cleaning checks, food delivery, etc.

I read and understand this rule and will follow it. _____

Visitors: All visitors must check in with the front desk volunteer or staff. There is a limit of two additional people in the apartment at a time. If you would like more guests, please contact Brent's Place Staff to make arrangements.

I read and understand this rule and will follow it. _____

Visiting hours are between 8:00 A.M. and 8:00 P.M. Media room and exercise room hours are between 8:00 A.M. and 8:00 P.M.

I read and understand this rule and will follow it. _____

A $125 Cleaning Fee is required from the residents on admission to Brent's Place. This is used to clean the apartment for your stay at Brent's Place and helps to clean it for the next family as well.

I read and understand this rule and will follow it. _____

Gaming systems: If you bring gaming systems to Brent's Place, you must set a time with our House Operations Manager to have him set them up for you.

I read and understand this rule and will follow it. _____

Quiet Hours: Brent's Place has Quiet Hours between 9:00pm-7:00am daily to ensure that everyone is able to rest.

I read and understand this rule and will follow it. _____

Moving Furniture: You are welcome to move the furniture in the apartment if you would like to. We do ask that you move everything back to the way you found it when you move out. Please do not move furniture during quiet hours.

I read and understand this rule and will follow it. _____

Phone Service: Phone service in apartments does not include long distance, last number redial or directory assistance. Charges for these services will be billed to you.

I read and understand this rule and will follow it. _____

Keys: Each family is issued a maximum of two sets of keys. Brent's Place staff will replace lost keys for a $15 charge.

I read and understand this rule and will follow it. _____

Communicating Rules: You are responsible for making sure all Caregivers in your unit understand and agree to these rules & guidelines.

I read and understand this rule and will follow it. _____

"Safe-Clean" Rules and Guidelines

No pets allowed at any time on Brent's Place Property. This includes every kind of animal, including fish. Do not feed the squirrels, cats or any other animals around Brent's Place.

I read and understand this rule and will follow it. _____

Only the patient, caregiver(s), and siblings as listed on the occupancy agreement may occupy apartments. Maximum occupancy in an apartment is four people. Any desired changes to the occupancy list must be approved by the Brent's Place Family Services Manager.

I read and understand this rule and will follow it. _____

The apartments must be kept "safe-clean" according to Brent's Place Cleaning Guidelines (see below). The apartments must be kept clutter-free and organized. No carpets or rugs can be brought into the facility. All bedding (blankets, pillows, sheets, etc.) must be laundered and sealed in a plastic bag before bringing them into our facility. These guidelines promote the health and well-being of the patient(s) in treatment.

I read and understand this rule and will follow it. _____

Fresh plants and flowers are not allowed in the apartments. Organisms that grow in dirt, water and plants can cause infections.

I read and understand this rule and will follow it. _____

Candles, incense or anything that you light with fire are not allowed to be used in the apartments.

I read and understand this rule and will follow it. _____

All Brent's Place common areas will be respected and kept clean. This includes hallways, laundry rooms, playgrounds, multipurpose room, media room, exercise room, elevator, and parking lots.

I read and understand this rule and will follow it. _____

All trash must be disposed of in the dumpster. Please do not leave trash in hallways, common space, or parking garage.

I read and understand this rule and will follow it. _____

Do not invite family members or friends who may be sick to Brent's Place. We try very hard to maintain an environment free of virus, bacteria and infections due to our vulnerable patient population.

I read and understand this rule and will follow it. _____

Brent's Place can and will ask you to terminate your stay at Brent's Place if any of our rules are violated. In addition to rule violation, Brent's Place may terminate your stay for the following two reasons:

- **Treatment for the patient is no longer required.** Patients being treated for issues other than those in compliance with Brent's Place criteria are not eligible for housing.
- **Incoming, Post-Transplant pediatric patient in need of housing has priority for admission.** This is based on Brent's Place Admission Criteria.

Signature of Compliance of Brent's Place Rules and Policies

- I have read, understand and agree to the rules and policies, as well as the cleaning guidelines (on the following page) at Brent's Place. I understand that failure to comply with these guidelines can and will result in the termination of stay.
- I understand that Brent's Place staff will make regular periodic cleaning checks on the apartment to ensure compliance with these standards.

Caregiver 1:

Please Print Name: _____ Date: _____

Signature: _____

Caregiver 2:

Please Print Name: _____ Date: _____

Signature: _____

Brent's Place Cleaning Guidelines

Cleaning Guidelines Please utilize cleaning supplies provided by Brent's Place.	Times week.	Initial
GENERAL (Living Area & Bedrooms)		
Take out all trash to dumpsters.	Daily	
Dust & Clean all furniture and appliances (TV).	Daily	
Damp wipe Door Knobs & Light Switches, especially in bathrooms.	Daily	
Sweep & Mop Hardwood Floors, including under furniture.	Daily	
Damp wipe windows, sills, and blinds.	3X	
Move couch and clean under and behind it.	3X	
Wash Windows	1X	
Dust/Clean Baseboards.	1X	
Dust/Clean corners of rooms.	1X	
Dust/Clean Tops of Picture Frames.	1X	
Clean Lampshades and Light Fixtures	1X	
Remove all couch and chair cushions and clean underneath.	1X	
KITCHEN:		
Sweep & Mop Kitchen Floors.	Daily	
Damp Wipe Kitchen Counter tops.	Daily	
Pour bleach in the drain in the kitchen sink	1X	
Wash dishes in dishwasher and dry.	Daily	
Wash sponges in dishwasher.	Daily	
Clean Microwave, inside and out.	3X	
Damp Wipe outside cabinet doors.	3X	
Damp Wipe inside cabinets.	1 X	
Thoroughly clean inside refrigerator, throwing away any old food.	1 X	
Damp Wipe top of refrigerator.	1X	
Pull Refrigerator out and clean floor underneath.	1X	
Clean Stove: wipe inside & out.	1X	
Remove bottom shelves of stove and clean floor below.	1X	
BATHROOM:		
Sweep and Mop Floor.	Daily	
Clean/Scrub sink.	Daily	
Clean/Scrub toilet.	Daily	
Clean/Scrub tub/shower	3X	
Clean Mirror.	1X	
Dust/Clean any shelving and cabinets, inside and out.	1X	
Pour bleach in the sink and tub drains	1X	
LAUNDRY:		
Wash towels.	3X	
Wash bedding: sheets, mattress pads, pillow liners, and blankets.	1X	
Wash potholders.	1X	
Wash comforters.	Bi-monthly	

Please initial each section and sign & date <u>below</u>, noting you understand the guidelines and will maintain them while staying at Brent's Place.

Print Name: _____ **Signature:** _____ **Date:** _____

Authorization for Disclosure of an Individual's Health Information

Subscriber or Dependent Whose Information is to be Disclosed:

_____ _____

Patient Name Policy #

_____ _____

Street Address City State Zip Daytime Phone Number

Person(s) or Entity(ies) to Whom Information May Be Disclosed

Brent Eley Foundation dba Brent's Place.

11980 E 16th Ave, Aurora, CO 80010 Phone: 720-343-2802 or 720-343-2800 Fax: 303-831-4567

Information to be disclosed by _____ at the request of the individual authorized to do so. (Insurance Company)

- Health Plan Benefit Information: Includes information contained in your benefit booklet (i.e. copayments, coinsurance, eligibility and other benefit information.)
- Claims Information: Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (i.e., billed amount, claim payment, denial reason, etc.)
- Authorization Information: Includes information regarding precertification and authorization, including specific medical information related to requests and determinations.
- Other: please specify: _____

Length of Time for Which This Authorization is Valid

Under applicable law, this authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. This authorization will remain in effect until:

____ 24 months from the date of signature of this authorization.

____ Until _____, but no longer than 24 months from the date of signature.

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability to obtain treatment, payment or eligibility for benefits. However, there may be some consequences with the intended recipient of this information.
- I understand this authorization is not valid without the required signature.
- I understand that I have the right to revoke this authorization at any time in writing, except to the extent that my insurance company has already provided the information.
- I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization therefore; the privacy law may no longer protect my information.

I authorize billing and payment directly between the within named Insurance company and Brent's Place.

_____ _____ _____

Print Full Name Signature Date

Relationship/Authority: Please check one. ___Member ____Parent of Minor Child

Please provide documentation if you are: ___Power of Attorney ___Legal Guardian

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HIPPA Form Instructions

The following HIPPA form allows Brent's Place to communicate with Children's Hospital about your hospital appointments and inpatient stay(s). It is very important that EVERY patient at Brent's Place who is receiving treatment at Children's Hospital signs this form. To provide us with the information we need, please:

1. Fill out Patient Name and Birth Date
2. Under "Records are requested for the purpose of," please select "Other Lodging/Insurance assistance"
3. For Part 1, "Type of records to be released and dates," please check Inpatient, Outpatient Testing and Physician Office/Clinic. For each area, please provide a two year date range beginning with today's date.
4. Sign and date at the bottom.

If you have any questions about filling out the forms please let me know or talk to your hospital social worker for help filling it out.

* ATTN: HIM - already provided by UCBL. DO not process this request - scan into records only *

HIPAA Authorization to Use/Disclose PHI

Patient Name | Date of Birth | Medical Record #

Section 1: I hereby authorize **Children's Hospital Colorado (CHCO)** to release information, as described below, to:

Name of Individual/Organization to receive information: Brent Eley Foundation (DBA Brent's Place)

Address: 11980 E. 16th Ave Aurora CO 80010

Phone number: 720·343·2802 Fax number: 303·831·4567

For the purpose of: ☐ Continuing Care/Treatment ☐ Legal ☐ Personal Use ☐ Insurance

☒ Other (please describe): Financial Assistance

Section 2: Type of records and dates to be released*

☐ Entire Legal Medical Record

☐ Pertinent Legal Medical Records Only [including: Provider Progress Notes and Reports, Emergency Dept. Reports, Discharge Summary, Lab/Pathology reports, Imaging Reports, Operative/Procedure Reports, EKG Report]

Other records:

☐ Telephone Consults	☐ Immunization Record	☐ Nurses Notes	☐ Audiology Tests
☐ Clinical Social Work	☐ ECHO, EEG, EMG, PFT Tests	☐ Genetic Testing	☐ Radiology Images
☐ Drug/Alcohol Treatment	☐ Behavioral Health Records	☐ HIV/AIDS Records	☐ Billing Information

☒ Other: Application completed with basic medical information & treatment dates.

Dates of Services (between): January 2019 and January 2018

Please Note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases.

***Patient signature required below to release these department specific records:**

Patient age **13 or older**: Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.

Patient age **15 or older**: Behavioral health or psychiatric care information.

Release method: ☐ Paper ☐ CD *(only available for records stored electronically)* ☒ Verbal

Delivery method: ☐ Mail ☒ Fax * email/phone

I understand the following: This authorization will automatically **expire** 1 year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than 1 year. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying CHCO in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. I will be provided a copy of this authorization upon fulfillment of the request. CHCO will still provide treatment and seek payment for services provided, whether or not I sign this authorization. CHCO may charge for copies of medical records.

Signature | Date | **Signature of Patient** (when required)

☐ Parent or Personal Representative ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

CHCO HIM • 13123 E. 16th Ave, Box 150, Aurora, CO 80045 • Ph: 720-777-4259 • Fax: 720-777-7251
CHCO Radiology • Email: radiology.archive@childrenscolorado.org • Ph: 720-777-8625 • Fax: 720-777-7132
ROI @ Briargate • Ph: 719-305-9562 • Fax: 719-305-9702