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

APPLICATION FOR FAMILY ASSISTANCE

Date: _____

Name of Patient: _____
Last First Middle Initial

Patient's Date of Birth:_____ SS#:_____

Hospital: _____ Physician: _____

Guest's Signature: _____

Social Worker Telephone: _____ Pager: _____

Social Worker's Signature: _____

Standard Cost of Apartment:	$93/per night
Reduced by:	_____
Cost of room after reduction:	_____ (This rate applies to applicant only)

NOTE: PLEASE FAX PAGES 1-3 TO LYNNDA SIMPSON 303-831-4567

Third Party Billing Information:

Primary Insurance: _____

Phone #: _____ Plan #: _____ Group #: _____

Caseworker Name: _____ Caseworker Phone/email: _____

Secondary Insurance: _____

Phone #: _____ Plan #: _____ Group #: _____

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APPLICANT'S INFORMATION:
The following information pertains to the guest requesting the reduced rate.

Name: _____
Last First Middle Initial

Address: _____
Street

_____
City State Zip Code

Phone number: _____

Relationship to Patient: _____

Employer name: _____

Address: _____
Street

_____
City State Zip Code

SOURCES OF INCOME: **Last 12 months**

Wages/Self-Employment _____

Public Assistance _____

Social Security _____

Unemployment/Worker's Compensation _____

Alimony and/or Child Support _____

Other Income _____

TOTAL ANNUAL FAMILY INCOME _____

NOTE: You may be asked to verify your income.

Number of Persons in your Household: _____

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, Lynnda Simpson, Allen Browning

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, expect 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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Please provide additional information describing your financial situation:

Clinical Social Work Assessment: