NICK'S HOUSE RESIDENCY APPLICATION

The HEADstrong Foundation (HF) makes available temporary housing on a limited basis for patients receiving treatment in Philadelphia area hospitals for cancers and related disorders and their family members accompanying them in connection with such treatment.

Eligibility Requirements:

Residency applicants must meet the following eligibility requirements:

- Undergoing cancer treatment at time of application
- Applicants must travel at least 50 miles one way from Philadelphia, 19103.
- Minimum stay of 14 days is required.
- Each guest must be accompanied by a caregiver over the age of 18 to stay with them.

Application:

Prospective residents must submit a completed Application in the form attached. Incomplete applications will not be considered. The Application requires a referral by a health professional (e.g., physician, nurse, or oncology social worker) familiar with the applicant's medical condition and course of treatment.

Professional References:

Every adult patient and guest over 18 years of age must provide a professional reference as a condition to having their application considered. A professional reference may not be a family member and may include an employer or former employer, co-worker or former co-worker, member of the clergy or social worker (with whom the applicant has worked for more than 30 days).

Terms and Conditions:

Nick's House is not a healthcare facility and may not be used for the purpose of the administration of medical care or therapies, including, without limitation, palliative or hospice care. HF makes its residential facilities available for such persons from time to time, in the HF's sole discretion. Use of residential facilities is subject to the rules and requirements of HEADstrong Foundation. All residents must sign a Nick's House Guest Agreement, the form established by the HF. Length of stay is up to 6 weeks, extensions may be approved at the discretion of the board.

Please send the completed application to info@headstrong.org

NICK'S HOUSE
RESIDENCY APPLICATION

Must be completed by the Patient • Incomplete Applications will not be considered

Patient Name: _____
Last First M.I.

Address: _____

City _____ State _____ Zip _____

Primary Phone #: _____-_____-_____ Secondary Phone #: _____-_____ - _____

E-Mail: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____ - _____

Gender: ❑ Male ❑ Female Annual Income: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Relationship with Patient: _____

Emergency Phone #: _____-_____-_____ Emergency Phone #: _____-_____ - _____

Arrival Date: _____/_____/_____ Departure Date: _____/_____/ _____

Diagnosis: _____ Date of diagnosis: _____ / _____/_____

Do you have health insurance? ❑ Yes ❑ No Do you have a prescription drug plan? ❑ Yes ❑ No

Do you have Medicare? ❑ Yes ❑ No Do you have Medicaid (Title 19)? ❑ Yes ❑ No

Hospital Where Receiving Treatment: _____

Treating Physician: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____-_____ - _____ Phone #: _____-_____ - _____

E-Mail: _____

❑ _____ I authorize HEADstrong Foundation to contact my medical team to validate this application and I have made them aware of my application for a stay at Nick's House.
Initial

Patient Professional Reference: _____

Phone #: _____ - _____ - _____ Relationship with Guest: _____

OTHER GUESTS STAYING WITH PATIENT

Caregiver Name: _____ Age: _____

Phone #: _____ - _____ - _____ Relationship with Patient: _____

Address: _____

City _____ State _____ Zip _____

E-Mail: _____

Professional Reference: _____

Phone #: _____ - _____ - _____ Relationship with Guest: _____

Guest 1 Name: _____ Age: _____

Phone #: _____ - _____ - _____ Relationship with Patient: _____

Address: _____

City _____ State _____ Zip _____

E-Mail: _____

Professional Reference: _____

Phone #: _____ - _____ - _____ Relationship with Guest: _____

Guest 2 Name: _____ Age: _____

Phone #: _____ - _____ - _____ Relationship with Patient: _____

Address: _____

City _____ State _____ Zip _____

E-Mail: _____

Professional Reference: _____

Phone #: _____ - _____ - _____ Relationship with Guest: _____

Will patient or any guest require special accommodation? ❑ Yes ❑ No

Nick's House is ADA handicapped accessible.

If "Yes", explain: _____

_____

_____

Please explain how housing services from the HEADstrong Foundation will assist with financial hardship caused by your medical condition (attached additional sheet if needed):

_____

_____

_____

_____

_____

_____

_____

The undersigned certifies to HF that he/she meets the eligibility requirements of the Nick's House Residential

Services Program, as described in this Application, and that all the information provide in or with this Application is true and correct.

Patient Signature:_____Date of diagnosis:_____ / _____ / _____

Printed Name:_____

❑ I give permission for the HEADstrong Foundation to send communications regarding its activities using the contact information,

above.

If the patient is a minor, the undersigned parent or legal guardian of the patient signs on the patient's behalf:

Parent/Legal Guardian Signature: _____Date of diagnosis:_____ / _____ / _____

Printed Name:_____

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