New Patient Application

The Casey Cares Foundation provides ongoing support to critically ill children and their family members. Questions? Call 443-568-0064 or visit CaseyCares.org

Casey Cares Foundation

Child's Name: _____
First Middle Last

Alternative name (Nickname): _____

Birthdate: ___/___/_____ **Age:** _____ **Male** □ **Female** □
Month/Date/Year

Home Address: _____
Street Apt#

_____
City, State Zip Code County

Home Phone: _____
Area Code Number

Cell Phone: _____ **Please check: Father** □ **Mother** □ **Other** □
Area Code Number

Cell Phone: _____ **Please check: Father** □ **Mother** □ **Other** □
Area Code Number

Email: _____ **Please check: Father** □ **Mother** □ **Other** □

Email: _____ **Please check: Father** □ **Mother** □ **Other** □

Parent/Guardian: _____ **Relationship to patient:** _____
(please print)

Parent/Guardian: _____ **Relationship to patient:** _____
(please print)

Social Worker/Child Life Worker's name: _____

Primary Physician's name: _____

Hospital: _____

The Participant authorizes the release of any confidential protected health information, as defined by HIPAA 45 C.F.R. Parts 160 and 164. The Participant understands that this authorization is voluntary and that the information to be disclosed is protected by law. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient to any third party involved in program participation. Participant does also hereby covenant not to sue Casey Cares for any matter arising out of or connected with such release and/or disclosure of any confidential protected health information.

Parent/Guardian: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

Please complete all sections and sign the application. Doctor and social worker must complete reverse page before returning to foundation.

OVER

Office Use Only v 2.17
New _____ **Update** _____

Child's name: _____

PHYSICIAN'S DOCUMENTATION

This medical evaluation is being completed and signed by _____
Please print

Hospital : _____ City/State _____

Phone: _____ Fax: _____ Email: _____

Child's illness: _____

Is child frequently hospitalized? Yes □ No □ Is child on active treatment? Yes □ No □

Is child on hospice care? Yes □ No □ Is child's illness critical and/or life-threatening? Yes □ No □

If at least 2/4 above criteria are not met, please explain the reason that child should still qualify for programs

_____

_____

Initial date of diagnosis: _____

Last treatment date: _____ Date of last office visit: _____

I am the primary physician for this child. The Parent(s)/Guardians(s) have full knowledge of child's illness and are aware of how to handle medical emergencies. If Parent(s)/Guardians(s) adhere to physician's recommendations/instructions, there is no medical contraindication to patient's participation in Casey Cares Programs and patient will not present medical risks to others.

_____

Physician's Signature Date

SOCIAL WORKER/CHILD LIFE WORKER INFORMATION

Name: _____

Phone: _____ Fax: _____ Beeper: _____
Area Code Number

Email: _____

Additional information about family: _____

Please let us know if you need additional information about Casey Cares guidelines or programs

_____

Social Worker/Child Life Worker's Signature Date

When completed, please forward to:

Casey Cares Foundation
3918 Vero Rd., Suite C
Baltimore, MD 21227

Phone: 443-568-0064
Fax: 443-524-9949
Email: Erin@CaseyCaresFoundation.org