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.
- All patients staying at Nick's House must be accompanied at all times by an adult caregiver capable of meeting the daily care needs of the patient. Patients without an appropriate caregiver will not be permitted to stay at Nick's House.

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: ____

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

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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: ____

Please send the completed application to info@headstrong.org