

# MOMMY'S LIGHT® REQUEST FOR SERVICES APPLICATION

## YOUNG PERSON'S INFORMATION:

Name	Gender	Birth Date	Age

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Names of other people under the age of 18 living in the house and relationship to family: \_\_\_\_\_  
\_\_\_\_\_

## PARENT/LEGAL GUARDIAN AND FAMILY INFORMATION:

Parent(s)/Guardian(s) – Circle one – Name(s): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Address, if different from home address above: \_\_\_\_\_  
\_\_\_\_\_

## REFERRING PERSON:

Name: \_\_\_\_\_ Relation to Family: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Are there any issues with the child/family that we need to be aware of (for example: custody issues, communicable disease, immigration status, ability to sign paperwork, etc.) Yes\_\_\_ No\_\_\_ ***If yes, please provide explanation on the back of this form***

## INFORMATION REQUIRED TO DETERMINE ELIGIBILITY:

Mother's Name: \_\_\_\_\_

In order to be eligible for Mommy's Light's services, the young person's mother must have a life-threatening illness or be deceased. Please provide the information in Section A (and Attachment A) below if the mother has a life-threatening illness or Section B below if the mother is deceased.

### Section A – The Mother has a life-threatening illness.

Name of Mother's Primary Doctor: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Doctor's Fax: \_\_\_\_\_

Mother's medical diagnosis: \_\_\_\_\_

### Section B – The Mother is deceased.

Date of Mother's Death: \_\_\_\_\_ Circumstances of Mother's Death: \_\_\_\_\_  
\_\_\_\_\_

Please attach evidence of mother's death (i.e., a copy of the death certificate).

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ATTACHMENT A

## MOTHER'S AUTHORIZATION OF MEDICAL INFORMATION RELEASE:

I, \_\_\_\_\_, hereby give Mommy's Light Lives On Fund® permission to contact my Physician regarding the nature of my illness in order to determine whether my child(ren) are eligible to make a request from "Mommy's Light." I also hereby give my Physician permission to complete the Mommy's Light Medical Authorization Form regarding my illness.

Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MOTHER'S AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HIV-RELATED INFORMATION: (if applicable)

HIV-related information is information which concerns whether a client/patient has been tested for HIV, has AIDS or an HIV-related illness, or could reasonably identify the client/patient as having one or more of these conditions.

I, \_\_\_\_\_, authorize Mommy's Light Lives On Fund® to release confidential HIV-related information about myself to the applicable Mommy's Light staff/volunteers for the purpose of fulfilling my child(ren)'s request for services. I understand that I may revoke this consent at any time except to the extent information has already been released in reliance to this form.

This consent will expire two years from the date of signing.

I have ready and fully understand the above statements as they apply to me. I consent to the release of records/information for the purpose stated above.

Mother's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_\_\_