ALEX C DOVE FOUNDATION

Respite Housing Application

ELIGIBILITY

The applicant (adult/child) must be undergoing, or have been in treatment within the last year, or under hospice care for a life-threatening illness.

It is our goal to offer guests up to a week stay at Dove's Nest cabin free of charge. The cabin is located on Lake Camelot in the town of Rome, Wisconsin.

APPLICATION

In order to be considered for participation in our program the applicant/applicant's family must submit a completed application. All forms must be signed or, if child, then a parents/guardians must sign. **The medical assessment MUST be filled out and signed by the physician.**

Acceptance at Dove's Nest is contingent upon receipt of **all** completed forms and approval by the Alex C. Dove Foundation Board. Guidelines and eligibility requirements must be followed.
The completed application is due no later than 2 weeks prior to the requested stay with a $250 deposit that will be held in escrow for any damages to the Dove's Nest during the stay.

Approved applicants will be required to enter a 'rental' agreement.

Our first priority is families with the greatest need.

The deposit amount will be returned once the guests leave and verification has been made that the house has not been damaged or suffered any lost items or equipment.

RESPITE HOUSING ELIGIBILITY REQUIREMENTS

A qualified applicant must have been in treatment and seen by a doctor within the last year or under hospice care.

Guests must:

- Provide their own transportation to and from the Dove's Nest.
- Provide their own meals.
- Be respectful and responsible, with no indication of inability to abide by rules/regulations.

GUEST APPLICATION

The Alex C. Dove Foundation offers Dove's Nest, a cabin designed to offer those struggling with a life-threatening illness a free place to rest and relax.

PART I (To be completed by an adult patient or by parent/guardian if child is the recipient)

Patients Name

_____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ Age_____ Sex____M____F
(Month/Day/Year)

Home Address _____ _____
(Number/Street Address) (County)

City _____ State_____ Zip _____

Phone_____ Cell Phone_____ Email_____

Employer Name, Address & Phone_____

If patient is under 21:

Mother's Name: First_____ Last_____Phone_____

Employer's Name & Address _____

Father's Name: First_____ Last_____Phone_____

Employer's Name & Address_____

Emails: Mother _____Father_____

Legal Guardians (if other than parents)_____Phone_____

Address_____Email_____

Employer Name & Address_____

Note: If child is under the custody of one parent or guardian, please attach a copy of the child custody order or both parents or guardians must sign documents.

Names and ages of all other persons that will also be staying at Dove's Nest. Attach additional sheet if needed. The cabin has accommodations for no more than 8 guests at one time.

1.Name	Birth Date	Relationship
2.Name	Birth Date	Relationship
3.Name	Birth Date	Relationship
4.Name	Birth Date	Relationship
5.Name	Birth Date	Relationship
6.Name	Birth Date	Relationship
7.Name	Birth Date	Relationship
8.Name	Birth Date	Relationship

Hospital where patient is being treated if applicable.

_____City_____State_____

Physician_____ Phone_____

Please describe the type of life-threatening illness and any special needs or considerations:

We do not offer nursing care or any hospital equipment i.e. oxygen, etc.

Parents, in a divorced or separated situation, must both agree to share the opportunities our program provides. If parents are not able to do so, we will work with the parent who has legal custody of the child. **A copy of the court ordered custody agreement will be required with the application.**

I/We understand and recognize participation at Dove's Nest is contingent upon approval by the Alex C. Dove Foundation Board of Directors as well as compliance with all conditions, qualifications and restrictions designated by the Alex C. Dove Foundation. **We give the Alex C. Dove Foundation permission to speak with the doctor to verify the information in Part II (Medical Assessment is accurate).**

Patient_____ Date_____

Parent/Guardian_____ Date_____

PART II – Medical Assessment: (To be Completed by physicians)

Name of physician completing assessment (Please Print)_____

Hospital_____City_____State_____

Phone_____Fax_____

Diagnosis_____ Date of Diagnosis_____

The condition is considered life-threatening: Yes_____ No_____

The patient is currently undergoing treatment: Yes_____ No_____
Please list treatment(s):
_____
_____

How often is the patient seen by a physician? _____

Date of last visit: _____

I (the Physician) have explained the applicant/patient's medical condition to the family and have instructed them on how to handle medical emergencies. As long as the family takes sufficient precautions to protect the applicant/patient in accordance with the physician's instructions, there is no medical contraindication to applicant/patient's participation at Dove's Nest.

Physician's Signature_____ Date_____

Comments:

LIABILITY RELEASE / AUTHORIZATION DISCLOSURE

As a requirement for participation at Dove's Nest the following must be completed in full by the primary adult staying at the cabin.

Liability Release: The undersigned individually, jointly and on behalf of the patient, and other guests during the patient's stay (the "participants"), understands involvement in the Alex C. Dove Foundation Dove's Nest cabin may involve risk of injury or harm to the participants and all risk is fully assumed by the undersigned. The undersigned both individually, jointly, and on behalf of the patient and the participants, does hereby agree to release, forever discharge, and hold the Alex C. Dove Foundation, their directors, officers, employees, agents, volunteers, successors and assigns harmless from and against any and all actions, causes of action, liability, claims and demands for, any damages and claims of any kind whatsoever, whether known or unknown, in connection with or arising from any incident(s) or occurrence(s) during the patient's and participants' participation or consideration of participation at the Alex C. Dove Foundation Dove's Nest cabin.

Authorization to Disclose and Obtain Medical Information: The patient, or parent(s) or legal guardian(s) give The Alex C. Dove Foundation authorization to obtain all medical information which the Alex C. Dove Foundation may feel is necessary for the consideration or participation at the cabin. The patient, or parent(s) or legal guardian(s) authorize all of the patient's physicians and medical care providers to provide the Alex C. Dove Foundation with all medical information regarding the patient applying to participate at the Dove's Nest cabin.

Authorization for Disclosure to Third Parties: The patient, or parent(s) or legal guardian(s) understand and agree the Alex C. Dove Foundation may disclose their patient's identifying information to a third party in order for the third party to provide notices to the parent(s) or legal guardian(s), such as when some unforeseen issue occurs whereby we need to cancel (i.e. weather, etc).

Authorization Regarding Publicity: It is understood and agreed that participation in the Alex C. Dove Foundation may result in publicity, and that in order for the Alex C. Dove Foundation to continue its service, it is helpful to be able to portray patients and families using the cabin in a positive way in brochures, newsletters, on the Alex C. Dove Foundation website, and other promotional materials. The undersigned both individually and on behalf of the patient and participants authorize the Alex C. Dove Foundation to use the name of the patient/family for publicity or promotional purposes.

Authorization Regarding Photo: Due to the nature of the Alex C. Dove Foundation, publicity is sometimes unavoidable. Although the Alex C. Dove Foundation cannot control outside media, the undersigned as the patient, or parent(s) or legal guardian(s) of the patient, by checking below, may grant or deny permission for the Alex C. Dove Foundation to use photographic images of the patient and/or family and participants in the Alex C. Dove Foundation promotional materials, such as brochures, newsletters, websites, press releases, and any other means.

The undersigned understand and agree that if they deny permission, the Alex C. Dove Foundation will exercise its best efforts to prevent use of the photographic images but cannot make any guarantee with respect to publicity.

Please complete and sign below. Please place a check or X in the appropriate blank.

_____ I GRANT

_____ I DENY

Permission for the Alex C. Dove Foundation to use a photographic image of the patient and/or family and participants in promotional materials.

The Liability Release and Authorization to Disclose Information contains the entire agreement between the patient, or parent(s) or legal guardian(s) and the Alex C. Dove Foundation and the terms hereof are contractual and not a mere recital. By signing below, the patient, or parent(s) or legal guardian(s) of the patient acknowledge they have read, understand and consent to the terms set forth herein.

Patient's Name_____

Date of Birth _____

Diagnosis of Patient_____

Home Address_____

City_____ State_____ Zip_____

( )____-_____ ( )____-_____ ( )_____-_____
Home Phone Work Phone Cell Phone

Email_____ Emergency Phone ( )_____-_____

(If a child has two parents or legal guardians, both parents and legal guardians must sign below.)

Parents/Guardian_____ Date_____

Parent/Guardian_____ Date_____

Witness_____ Date_____

No pets allowed unless medical aid approved. Certification of such must accompany this application.

CHOICE OF DATES

Guests can stay up to 6 nights and 7 days. Please check the website calendar for available dates.

Check In – 4:00 pm

Check Out – 11:00 am

Please provide us with your dates of choice: (i.e. calendar date and day of the week)

1st Choice_____

2nd Choice_____

3rd Choice_____

Dates are subject to first come first serve basis.

We cannot confirm your dates until the application process has been approved, we have received the signed House Rules and the refundable deposit of $250 is secured.

Please complete all sections of this form and return to:

Alex C. Dove Foundation
928 Sussex Court
Nekoosa, WI 54457