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:** _____

I have reviewed the included Waiver and Release provided along with this application, a copy of which is also provided on the Casey Cares website, the terms of which are incorporated herein by reference.

_____ (initial) _____ (initial)

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 8.20
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
7100 Columbia Gateway Drive, Suite 155
Columbia, MD 21046

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

CASEY CARES FOUNDATION, INC.
PARTICIPATION WAIVER AND RELEASE

In consideration of being allowed to participate in one or more of the programs or other offerings provided by the Casey Cares Foundation, Inc. a Maryland 501(c)(3) non-profit organization ("Casey Cares") (hereinafter "Program"), and intending to be legally bound, the participant named below, by and through their legal parent or legal guardian, agrees for themselves, their heirs, executors, administrators and assigns (hereinafter "Participant"), to waive and release all rights and claims for damages which the Participant may have now or in the future against Casey Cares, its officers, directors, employees, agents, volunteers and affiliates, arising out of or relating in any way to the Programs, including all claims for personal injuries and/or property damage sustained by the Participant before, during, or after said Program, whether caused or alleged to be caused in whole or in part by the negligence or intentional misconduct of Casey Cares or otherwise. The Participant does also hereby covenant not to sue Casey Cares for any matter arising out of or connected with the Programs. The Participant does release and absolve Casey Cares, its officers, directors, employees, agents, volunteers and affiliates, from any and all actions, causes of action, claims and demands for, any damage for any incidents or occurrence which occur during the participation or consideration of participation in a Program.

The Participant does recognize that the Programs may involve activities that are physically demanding and may involve injury or harm and the Participant agrees that this risk is fully assumed by the Participant. This includes, but not limited to problems connected with transportation, lodging, food, all medical conditions, publicity to include photographs, accidental injury, death or harm to the Participant and that all risk is fully assumed by all Participant. Participants agrees to carry full medical coverage or assume personal responsibility for failing to carry adequate medical insurance.

The Participant gives Casey Cares permission to use its name, likeness, photograph and other information for purposes of promotion, publication, commercial advertising, or any purpose whatsoever, now or at any time in the future. The Participant also gives Casey Cares permission to use any photographs or video event that may be used for publicity. Casey Cares may use this information: (1) in all manner and media whatsoever; whether now or hereafter invented, including electronic and print media and the Internet; (2) with or without Participants' names; (3) without the payment of royalties or other compensation to anyone; and (4) without the need to notify them or to seek further approval before doing so. The Participant hereby releases Casey Cares, its officers, directors, employees, agents, volunteers and affiliates, from all liability, damages or claims resulting from, or arising from the use, distribution or disclosure of any photographs, films, newsletters, videotapes, websites, press releases or other information regarding Participant.

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.

By initialing page one of the application, the Participant agrees and acknowledges that they have read and fully understand the terms hereunder. It is further understood that this Participation Waiver and Release contains the entire agreement between the Participant and Casey Cares. By initialing, you agree and acknowledge that you have fully read and understand this agreement.

**This page does not need to be returned to the foundation and may be kept for your records.