Maribo Cares
17192 Murphy Avenue #17562
Irvine CA 92623
949-751-6064

Helping cancer fighters thru recovery

Request for Services Application

~ PLEASE READ THE FOLLOWING BEFORE CONTINUING ~

Non-Eligibility:

You will NOT qualify for services if any of the following apply:

- **I have never experienced cancer, cancer surgery, cancer treatment(s), and/or post-cancer follow-up surgery and/or treatment(s).**
- **I am receiving the same service(s) from another organization(s).**
- **I have falsified documentation/verification/information provided to Maribo Cares.**

Full Disclosure and completion of this form is required for your application to be accepted.

Application Instructions

1. Complete, initial, sign, and date **Request for Services Application** packet.
2. Return completed **Request for Services Application** packet to Maribo Cares.
3. Provide Maribo Cares with all necessary supporting documentation including a photocopy of Driver's License for proof of identity.
4. ENTIRE packet and ALL documentation must be completed in their entirety and submitted to Maribo Cares for consideration to receive services.
5. After receipt of your application, you will be contacted by a Maribo Cares team member to go over your application and customize your assistance.
6. Once approved, you will be connected to available services that meet your needs.

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Date: _____

Contact Information

**** Please PRINT legibly and use <u>BLACK INK</u> only. ****

Name: _____ _____ _____
Last First M Initial

Address: _____
City State Zip

Date of Birth: _____ **Email Address:** _____

Home Phone: _____ **Cell:** _____ **Wk:** _____

Type of cancer you are dealing with: _____

Treatment you are receiving & frequency:_____

- **Please check if permanently disabled.** **Please Check:** O **Male** O **Female** O **Other**
- **Please check if you are a returning Maribo Cares client.**

  Why?_____

<u>Emergency Contact</u>:

Name: _____ _____ _____
Last First Relationship

Address: _____
City State Zip

Home Phone: _____ **Cell:** _____ **Wk:** _____

If you needed assistance completing this application, please provide the person who helped you:

Name: _____ _____ _____
Last First Relationship

Home Phone: _____ **Cell:** _____ **Wk:** _____

<u>Authorized Representative For Your Information/Services</u>:

Name: _____ _____ _____
Last First Relationship

Home Phone: _____ **Cell:** _____ **Wk:** _____

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Date: _____

Services Offered

Please check boxes which apply to your needs:

____ House Cleaning ____ K-Laser Therapy ____3-D Areola Restoration

____Carpet Cleaning ____ Hair Wash/Dry/Head Massage ____ Food Box (60+ yrs)

____Therapy Dog Visit ____ Flower Delivery ____Volunteer Visits (Hospital / Home)

____ Phone Call Check-ins ____ Caring Cards ____Referrals to additional nonprofits

____Other Services Not Listed But Requesting_____

(Note:** If there is a service you would like, but it is not on our list, please let us know. We will make every effort to accommodate your requests as services become available. Availability of offered services is dependent upon vendors.)**

How did you hear about Maribo Cares?

Please check and answer the following, as it helps us to improve our services, assist our community, and most importantly, thank those who are kind enough to spread the word. Thank you!

____MC Website ____MC Twitter ____MC Instagram ____Internet Search

____MC Facebook Page ____MC Flyer ____MC Brochure ____MC Event

____Maribo Cares Staff Member/Volunteer, Name: _____

____Event, Name: _____

____Friend Referral, Name: _____

____Clinic/Doctor Referral, Name: _____

____Family Member Referral, Name: _____

____Word of mouth, Who? Name: _____

____Pet Care Facility, Name: _____

____Hair Salon, Name: _____

____Business, Name: _____

____Other Nonprofit, Name: _____

____Government Agency, Name: _____

____Other, Name: _____

Date: _____

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Previous Assistance Form

Please list all agencies/organizations from which you have received assistance, and/or are currently receiving assistance:

Agency/Organization

Address **City/State/Zip**

Tel # **Email Address**

Date of Service From **To**

Agency/Organization

Address **City/State/Zip**

Tel # **Email Address**

Date of Service From **To**

***** Please list any additional organizations on the back of this form. Thank you. *****

Income Level - Combined Household

(Income level does not have bearing on you receiving our services.)

◯ **Under $35,000/yr** ◯ **SSI/SSDI/Public Assistance** ◯ **Over $35,000/yr**

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AUTHORIZATION TO VERIFY HEALTH STATUS

Name of Doctor, Medical Group, or Agency

Address

(Area Code) Phone Number **Email Address**

Patient's Name: _____ **Tel #** _____

Date of Birth: _____ **Last 4 Digits Soc Security#:** _____ **Date of last Dr. Visit:** _____

Medical Insurance _____ **Group#:** _____

I, _____ , hereby authorize you to release to Maribo Cares nonprofit Organization, specific information requested by them that I cannot provide concerning my current health and/or treatment related to cancer.

This information is required to determine my eligibility for assistance from Maribo Cares. I have read, understand, and agree to this form/request prior to my signing.

Print Applicant's Name **Print Legal Representative's Name (if needed)**

Applicant's Signature **Legal Representative's Signature (if needed)**

Date **Date**

Please provide this completed form to the doctor, medical group, or agency from which you are requesting the release of information to Maribo Cares, and then return a copy of this completed form to Maribo Cares.

Full Disclosure and completion of this form is required for your application to be considered.

Date: _____

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Client Release, Waiver of Liability, and Indemnity Agreement

This agreement is made between Maribo Cares and _____, hereinafter respectively called Maribo Cares and the Client.

IN CONSIDERATION of Maribo Cares arranging for the provision of certain goods and services on behalf of the Client, Client hereby agrees to the following:

1. CLIENT HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE Maribo Cares, its directors, officers, employees, clients, and agents (hereinafter referred to as "releasees") from all liability to Client, and Client's agents, personal representatives, assigns, heirs, and next of kin for any property loss or damage, any personal injury loss or damage and any claim or demands therefor on account of injury to person or property of the Client, and Client's agents, or representatives, whether caused by the negligence of the releasees or otherwise.

2. CLIENT HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF PERSONAL INJURY OR PROPERTY DAMAGE that may be incurred arising from Maribo Care's operations in connection with providing goods and/or services to the Client.

IT IS FURTHER MUTUALLY AGREED between the parties that:

CLIENT HAS READ AND VOLUNTARILY SIGNS THIS AGREEMENT AND THE INCORPORATED RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT, and further agrees that no oral representations, statements, or inducement inconsistent with the foregoing written agreement have been made.

CLIENT:

Signature _____ **Print Name:** _____

Dated: _____

LEGAL REPRESENTATIVE:

Signature: _____ **Print Name:** _____

Dated: _____

Date: _____

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Signed Consent

I, _____, understand that by signing this consent, I hereby authorize Maribo Cares to connect me with vendors in my area that will provide the services for which Maribo Cares has offered to me and for which I have accepted.

By initialing the following, I agree and accept:

_____ I will not negotiate a change with the vendors to receive services other than or in addition to those offered by Maribo Cares.

_____ If I would like additional services from the contracted vendors outside of what is offered by Maribo Cares, I WILL ASSUME ALL COSTS. I WILL CONTRACT AND PAY THE VENDORS DIRECTLY.

_____ If I am unable to keep my appointment with a vendor or a Maribo Cares Volunteer, I will reschedule my appointment 24 HOURS PRIOR to the currently set appointment.

_____ I understand that all services are donated by the generosity of contracted vendors, and as such, a delay in scheduling appointments may occur.

_____ I understand that, all services are available dependent upon fluctuating demand, that during heavy demand, some services may become temporarily unavailable, and that these services will be provided as soon as they become available.

By signing below, I certify to the best of my knowledge that all information provided by me herein, is true and complete and any falsification of information will result in non-eligibility.

Print Applicant's Name	**Print Legal Representative's Name (if needed)**
Applicant's Signature	**Legal Representative's Signature (if needed)**
Date	**Date**

