

Michael's Place *let the healing begin*

ENROLLMENT FORM **For FAMILIES Requesting Michael's Place Services**

Today's Date _____

Your Name _____ Birthdate _____

Address _____ City _____

State _____ Zip _____ Home # _____ Cell# _____

Occupation _____ Employer _____

Work Phone _____ Hours to reach you there _____

Spouse's Name, if applicable _____ Birthdate _____

Occupation _____ Employer _____

Work Phone _____ Hours to reach you there _____

Email address: _____

Would you prefer to receive our monthly newsletters: _____ electronically (with this e-mail)
_____ in the mail (hard copy)

Children who services are being requested for:

NAME (Include nickname) BIRTHDATE AGE GRADE IN SCHOOL

Are you the parent or legal guardian of these children?

Please list any other adults or children in your household, and their ages:

Who is the person who died? If more than one person, please use the backside.

Name: _____ Date of Birth: _____
Date of death: _____ Age: _____ Cause of death: _____
Relationship to adult(s) above _____
Relationship to children above _____
Preferred Starting Date in Program _____

What have the children been told about the death?

What beliefs do the children have concerning what has happened to the person who died?
(Heaven, with the angels, spirit world, reincarnation, etc)

Is there anything the children have not been told about the death?

Were the children involved in the funeral and burial?

What concerns do you have about each of the children and their grief work?

Have there been other changes or losses your family has experienced recently? (moving, loss of job, new school, other deaths, etc.)

Do you or your children have any special needs or conditions we should be aware of (i.e. learning disabilities, allergies, etc.)?

Signature _____

**MICHAEL'S PLACE
FAMILY RELEASE FORM**

We understand that Michael's Place is a support center and offers no therapy or counseling. The groups offer peer support. Our family is here to share our experiences of loss, and to interact with others who are coping with the death of a family member or friend.

We understand that group discussion content, writing and artwork may sometimes be used for training, teaching and educating the public about the needs of grieving people and/or research. Michael's Place will always ask permission to share any piece. At no time will names of any participants be released without permission.

As participants at Michael's Place, we will respect the confidentiality of all information gained from all participants. We can also expect that what we share will be held in strict confidence by all facilitators and other participants. Sometimes information that we share in our groups will be shared with other facilitators if it will enable them to better understand the needs of our family members, but that information will be held in confidence.

We understand that groups begin promptly. We agree to arrive at a reasonable time and understand, because it would be disruptive to groups, that we may not be able to attend group if we arrive late.

We will attend meetings regularly, and only miss when it is absolutely unavoidable. We understand that our growth as well as the well being of the groups depends on our regular attendance. We will notify our Group Leader or Program Staff of any planned absences. If we are absent more than twice without contacting the office, we will be contacted by phone or letter. If we are frequently absent (more than twice in one month without a valid reason) we understand that our family will be asked to give our spaces to another family on the wait list and we will be returned to the waiting list.

We understand that not all children are able to benefit from involvement in a support group. Occasionally, a child's behavior may be uncontrollable, disruptive or pose a danger to him/herself or others at Michael's Place. We will be informed of behavior problems regarding our child, and the group facilitators and program staff will evaluate whether it is beneficial for our child to continue in the group. If appropriate, we will be given referrals to other services that may be able to provide support to our child.

Signed: _____ Date: _____

Michael's Place has my permission to use pictures of myself and/or my family in any presentations to tell the Michael's Place story. _____ Yes _____ No

**MICHAEL'S PLACE
MEDICAL INFORMATION AND RELEASE**

Are you or any of your children being treated by a doctor for a medical or psychological condition in the past 12 months that Michael's Place needs to be aware of? If yes, please explain.

Are you or your child taking any medications? If yes, what?

Do you or your child have any allergies we should know about? (foods, medications, bee sting, etc.)

Are you or your child currently being seen by a counselor or therapist? If yes, please explain.

Providing the following information is optional but is extremely helpful to Michael's Place for use in research and funding needs.

How did you find out about Michael's Place services? (Check all that apply) Brochure Hospice
 Newspaper/Other media Physician/Hospital School Counselor/Therapist
 Minister/Clergy Funeral Home Friend/Family Other (describe) _____

School system children attend: _____

Ethnic background of adults: African American Asian Caucasian Hispanic
 Native American Multi Racial

Religious affiliation: _____

Household income level: Under \$10,000 \$11,000-\$20,000 \$21,000-\$35,000
 \$36,000-\$50,000 \$51,000-\$75,000 Over \$75,000

Please indicate if your family may meet any of these conditions:

Receive ADC Receive SSI Unemployed Handicapped

(Please specify handicap if applicable) _____

Marital status _____ Education level completed _____

THANK YOU FOR YOUR FEEDBACK. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.