

**Family Requesting Services  
Enrollment Form**

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Spouse's Name, (if applicable): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Your Phone #: \_\_\_\_\_ Spouse's Phone #, (if applicable): \_\_\_\_\_

Your Email Address: \_\_\_\_\_

Spouse's Email Address, (if applicable): \_\_\_\_\_

Would you like to receive our monthly calendar via email?  Yes  No

*\*Our calendars are also available on our website and on-site at our front desk.*

How did you hear about us? Please list source: \_\_\_\_\_

Have you or your spouse ever been convicted of criminal activity against a child?  Yes  No

If yes, please explain: \_\_\_\_\_

Who is the person who died? Please list below or additional in the notes section on the last page.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of death: \_\_\_\_\_ Age: \_\_\_\_\_ Cause of death: \_\_\_\_\_

Relationship to adult(s) above: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of death: \_\_\_\_\_ Age: \_\_\_\_\_ Cause of death: \_\_\_\_\_

Relationship to adult(s) above: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of death: \_\_\_\_\_ Age: \_\_\_\_\_ Cause of death: \_\_\_\_\_


Relationship to adult(s) above: \_\_\_\_\_

Is there any additional information you think we should know? Please explain.



***Self-Evaluation:***

Many people describe grief as a journey. Please indicate by marking an “X” on the line below at the place that you believe best represents where you are at this moment in your journey today.



(0) Just beginning   (25) some distance   (50) moderate distance   (75) substantial distance   (100) a long way


**Please answer the following questions based on how often they are true for you:  
always true, sometimes true, never true.**

- |   |        |           |       |
|---|--------|-----------|-------|
| 1. I get the right amount of sleep per night.   | always | sometimes | never |
| 3. I take care of my physical health through balanced nutrition, hydration, and movement. | always | sometimes | never |
| 3. My attendance and performance at work meets productivity expectations.                 | always | sometimes | never |
| 4. I feel I can ask for the help I need.  | always | sometimes | never |
| 5. I feel a sense of belonging in my community.   | always | sometimes | never |

Is there any other information you would like to share about your grief journey?

***Spouse's Self-Evaluation, (if applicable):***

Many people describe grief as a journey. Please indicate by marking an “X” on the line below at the place that you believe best represents where you are at this moment in your journey today.



(0) Just beginning   (25) some distance   (50) moderate distance   (75) substantial distance   (100) a long way



Please answer the following questions based on how often they are true for you:  
always true, sometimes true, never true.

- |   |        |           |       |
|---|--------|-----------|-------|
| 1. I get the right amount of sleep per night.   | always | sometimes | never |
| 3. I take care of my physical health through balanced nutrition, hydration, and movement. | always | sometimes | never |
| 3. My attendance and performance at work meets productivity expectations.                 | always | sometimes | never |
| 4. I feel I can ask for the help I need.  | always | sometimes | never |
| 5. I feel a sense of belonging in my community.   | always | sometimes | never |

Is there any other information you would like to share about your grief journey?

***Emergency Contact Information:***

Emergency Contact Name: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

***Demographics: (Optional—this information is used to help us obtain grants and other funding.)***

**Age Range:**  18-24  25-34  35-44  45-54  55-64  65 +

**Race/Ethnicity:**  American Indian / Native American  Asian  Black / African  
 American  Hispanic / Latino  White / Caucasian  Pacific Islander  Other

**Religious Preference (please specify):** \_\_\_\_\_

**Household Income:**  Under \$20,000  \$20,000- 29,999  \$30,000-\$39,999  
 \$40,000-\$49,000  \$50,000+

**Marital Status:** \_\_\_\_\_



***Children who services are being requested for:***

NAME (Include nickname)                      BIRTHDATE                      AGE                      SCHOOL                      GRADE

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Are you the parent or legal guardian of these children?     Yes     No

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, illness, divorce, 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.*)



***MEDICAL INFORMATION:***

Have you been treated by a doctor for a medical or psychological condition in the past 12 months? If yes, please explain.

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

Are you taking any medications Michael's Place needs to be aware of? If yes, what?

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

***MICHAEL'S PLACE FAMILY RELEASE FORM:***

We understand that Michael's Place provides support and offers no therapy or counseling. 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.

I have read and understand the Michael's Place Policies and Important Information included in the Enrollment Packet.

Michael's Place has my permission to use pictures of myself and/or my family. \_\_\_\_Yes \_\_\_\_ No

Signed:\_\_\_\_\_Date:\_\_\_\_\_

For Office Use Only:

Date of Enrollment: \_\_\_\_\_

Recommended Support Group:

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Planned Start Date: \_\_\_\_\_

Referral to Outside Resources:

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Other Follow-Up Needed:

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Notes: