MY HAPPY PLACE APPLICATION

Child's Name: _____

Date of Birth: _____ Age: _____ Male or Female

Address: _____

_____

Father's Name: _____Ph. #: _____

Mother's Name: _____ Ph. #: _____

Main Contact Ph. #: _____

Email Address: _____

Does the child live at this address permanently? _____

If no, does the child reside at the address where the bedroom makeover would take place, at least 50% of the time? _____

Please list siblings and their ages also living at this address: _____

_____

Does the child named on this applicant have a bedroom of his/her own? YES or NO

Does the child named on this applicant share a room with a sibling? _____
If yes, list name and age: _____

State child's documented diagnosis: _____

_____

At what age was the child diagnosed? _____

Is this a chronic or terminal illness? _____

Please give details of the kind of treatment the child is receiving currently: _____

_____

Does your child require any special equipment? (Ex: wheelchair, oxygen) _____

_____

As a parent, what are your wishes for the child's room? _____

_____

How would your child like to have their room? (colors, themes, favorite character, etc:

_____

_____

What benefit are you hoping the child will gain from having the bedroom makeover?

_____

Are you the owner of the property listed above? _____
If not, is the landlord aware of the makeover? _____
Landlord's name & address: _____ Ph #: _____

Publicity is vital to our organization. Would you be willing to participate in publicity for this project? (photo's and story on FB, website, newspaper and/or TV) YES or NO

***This will in no way affect our decision in regard to your application.**

***While not necessary, a photo of your child would be appreciated.**

I/WE confirm that all of the above information is true and correct by signing below:

_____

(Signature of parent or guardian)

_____

(Signature of person filling out this form, if other than a parent)

_____

(Landlord signature if property is not owned)

Please print off this form and take it to your child's healthcare provider to have them fill out. While we understand this can hold up an application, you may submit the application form immediately with the healthcare form to follow. However, we cannot do any work on the bedroom until his/her diagnosis has been verified and this form on file. Thank you!

Name and title of healthcare professional: _____

Address: _____

Phone No: _____

Name of potential bedroom makeover recipient: _____

Child's documented diagnosis: _____

(Signature of healthcare professional filling out this form)

**Note to healthcare provider: If the applicant left this form for you to fill out, please mail it back to MY HAPPY PLACE, PO Box 982, Mason City, IA 50402 *THANK YOU!*