

HeadNorth Response TWO Application

Applicant Information

Response TWO is an outpatient care program which focuses on supporting the rehabilitation and re-integration back into society for recent recipients of a spinal cord injury. It provides financial assistance to purchase adaptive tools and services, key partnerships for physical and psychological rehabilitation and a resource to answer the numerous on-going questions. To assist us with the selection process, please take time to thoroughly answer each question providing as much information possible.

Name	
Street Address	
City, State ZIP Code	
Contact Phone	
Email Address	
Date of Birth	
Gender	
Social Security Number	
Marital Status	
Number of Dependents	
Name of Person Filling-out Application	
Relationship to Applicant	

Injury Information

Injury Level	
Injury Date	
Cause of Injury	
Extent of Injury	
Prognosis	

Insurance, Hospital, Physician & Rehabilitation Information

Name of Insurance	
Policy Type	
Name of Hospital (if applicable)	
Contact Person / Phone #	
Primary Care Physician / Phone #	
Primary Rehabilitation Therapist / Phone #	

Financial Information

Source(s) of Income	
Are you currently employed? If so where?	
Annual Income	\$
If you are not employed, were you employed before your accident? If so, where?	
Annual Income	\$

Equipment Needed

Description of equipment / services requested. If multiple, please prioritize in order of importance	
What are the costs of the equipment / services you are requesting?	
Please explain whether your insurance company has been able to assist with the purchasing of any of the equipment requested	

Supplemental Information

How will this grant help you?	
Briefly describe your support system (i.e. family, friends, support groups)	
Briefly explain your immediate needs and concerns.	

Supplemental Information continued:

<p>Is there anything else you would like to tell us about yourself?</p>	
<p>How did you hear about HeadNorth?</p>	<p> <input type="checkbox"/> Sharp <input type="checkbox"/> Scripps <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Friend <input type="checkbox"/> Brochure <input type="checkbox"/> Media / TV <input type="checkbox"/> Newspaper / Magazine <input type="checkbox"/> On-line <input type="checkbox"/> Other </p>

Waiver and Truth Statement

By signing below, I acknowledge and agree that:

(1) HeadNorth, its directors, officers, employees and agents (the “HeadNorth Parties”) may ask for or learn of certain protected health information (“PHI”) relating to my injury. In order to provide such information to HeadNorth, I may be requested to provide my hospital or healthcare provider with written authorization to disclose my PHI to HeadNorth and/or the HeadNorth Parties. In connection with the foregoing, I understand that it is in my sole and absolute discretion whether to authorize the disclosure of certain PHI to HeadNorth and/or the HeadNorth Parties. I understand that if I authorize the disclosure of my PHI to HeadNorth and/or the HeadNorth Parties, I may revoke such authorization at any time by providing written notice to HeadNorth.

(2) I am authorizing HeadNorth to use my name, pictures, biography, any information contained in this application, and certain PHI for marketing purposes. HeadNorth may use this information on its website, during presentations, in brochures, in the HeadNorth newsletter, and in other similar marketing materials. I understand that I have the right to revoke my authorization at any time by giving HeadNorth written notice of such revocation. However, I understand that, based on the time of the month the revocation is received, HeadNorth may or may not be able to cancel my name, picture, biography, or other related information in any upcoming publication, but that it will make a good faith effort to immediately accommodate my request.

(3) I am volunteering to be a part of the HeadNorth Peer Support Program. If I need additional information regarding this program or what it entails, I shall contact a HeadNorth representative prior to signing and submitting this application.

(4) I understand that HeadNorth has no obligation to accept my application, and my selection and participation in the program, or receipt of any grant, is in no way guaranteed. Whether a grant is awarded and, if awarded, the amount and terms and conditions attached thereto, shall be made in the sole and absolute discretion of HeadNorth.

(5) If I have any questions regarding the program, this application, or the scope of my authorization under this application, I will contact a HeadNorth representative prior to signing and submitting this application.

By signing below, I acknowledge that all the information provided on this application is true and correct in all material respects, and any false or misleading information submitted herein is grounds for my immediate elimination from consideration.

I AGREE

Applicant Name (printed) _____

Applicant Signature _____ Date _____

If under the age of 18, please have parent or guardian sign this Grant Request

Guardian Name (printed) _____

Guardian Signature _____ Date _____