

Dear Applicant,

Thank you for your interest in the Children’s Medical Rehabilitation Program (CMRP). The following is an application for the CMRP. Please read the application carefully and follow all directions. If you have any questions, please email us at **IMPACT WITH HOPE**, ministries@impactwithhope.org. After you have filled out the application, please submit the application through the email. Make sure you save a copy for your own files.

**IMPACT WITH HOPE** will endeavor to locate sources to assist you in providing medical treatment for your child. Upon approval, each applicant must be prepared to pay a non-refundable application fee of $25.00 USD as well as a roundtrip ticket to the United States of America.

Please be advised that all applications are reviewed by **IMPACT WITH HOPE**, medical institutions and health care professionals and must be approved by all.

Documents must be completed and returned by email and/or mailed to our offices before any final determination will be made.

Sincerely,



Linda A. Greene, RN Ph.D.

President/CEO

**IMPACT WITH HOPE**

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| CERTIFICATION OF THE PHYSICIAN (form is from your child’s physician in the county you live) | [ ]  | Yes | [ ]  | No |
| Application | [ ]  | Yes | [ ]  | No |
| Photographs (Three full length photos include photos of affected sites) | [ ]  | Yes | [ ]  | No |
| Birth Certificates | [ ]  | Yes | [ ]  | No |
| Immunizations Records | [ ]  | Yes | [ ]  | No |
| Dental Records  | [ ]  | Yes | [ ]  | No |
| Hepatitis Negative | [ ]  | Yes | [ ]  | No |
| HIV Negative | [ ]  | Yes | [ ]  | No |
| Tuberculosis Negative | [ ]  | Yes | [ ]  | No |
| Chest x-ray and/or area affected | [ ]  | Yes | [ ]  | No |
| Echocardiogram | [ ]  | Yes | [ ]  | No |
| Authorization Guardianship Form: Two Notarized Forms: (Must be in English and native language where child is residing) | [ ]  | Yes | [ ]  | No |
| Guardianship form is signed by both parents (if not, give reason)  | [ ]  | Yes | [ ]  | No |
| Photocopy of adoption papers if child is adopted (if not applicable do not reply) | [ ]  | Yes | [ ]  | No |
| Photocopy of custody agreement or court order (if not applicable do not reply) | [ ]  | Yes | [ ]  | No |
| Photocopy of court order with appointment of guardian (if not applicable do not reply) | [ ]  | Yes | [ ]  | No |

**IMPACT WITH HOPE**

**Children’s Medical Rehabilitation Program Check List**

 **If application is not complete, the application will not be reviewed or accepted.**

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| **Other hospitalizations** |
| Year | Reason | Hospital |
|      |       |       |
|      |       |       |
| **Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, Hepatitis B and Tuberculosis.**  |
| HIV (if no, please send the negative test results from laboratory, must be signed by physician) | [ ]  | Yes | [ ]  | No |
| Hepatitis B (if no, please send negative test results from laboratory, must be signed by physician)  | [ ]  | Yes | [ ]  | No |
| Tuberculosis (if no, please send negative test results from laboratory, must be signed by physician) | [ ]  | Yes | [ ]  | No |
| Has the child ever had a blood transfusion? | [ ]  | Yes | [ ]  | No |
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| **MEDICATIONS & ALLERGIES**  |
| **List Child’s prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** |
| Name the Drug | Strength | Frequency Taken |
|       |       [ ]  mg [ ]  cc [ ]  units  |    times a day  |
|       |       [ ]  mg [ ]  cc [ ]  units |    times a day |
|       |       [ ]  mg [ ]  cc [ ]  units |    times a day |
|       |       [ ]  mg [ ]  cc [ ]  units |    times a day |
| **Allergies to medications and Other Substances** |
| Name the Drugs or Other Substances  | Reaction (put none if you had no reaction) |
|       |       |
|       |       |
|       |       |
| **SociaL**  |
| **Family**  | **Father’s Name** (first, middle, last) :        |
| **Mother’s Name** (first, middle, last) :       |
| **Name:****Lives With Legal Guardian** (if divorced/separated/abandoned):  |
| Home Phone:       | Work Phone:       |
| Cell Phone:       | Email:       |
| Are there any specific religious, cultural or other beliefs that you want us to know about? [ ]  Yes [ ]  No  |
| Please Explain:       |
| **Nutrition**  | Special diets or food restrictions? [ ]  Yes [ ]  No | Explain:       |
| Feed self? [ ]  Yes [ ]  No  | Chewing/swallowing difficulties? [ ]  Yes [ ]  No |
| (if no, explain):      |
| Number of meals you eat in an average day?       | Nausea/Vomiting after meals? [ ]  Yes [ ]  No  |
| Takes fluids well? [ ]  Yes [ ]  No | if no, explain:        |
| **Infant** | Breast [ ]  Yes [ ]  No  | Bottle [ ]  Yes [ ]  No | Bottle at night [ ]  Yes [ ]  No  | Formula [ ]  Yes [ ]  No  |
| **Infant****Nutrition** |  |  |  |  |
| What kind of Formula?       | Pacifier [ ]  Yes [ ]  No  |
| **Daily****Activities** | Bladder Changes [ ] Yes [ ]  No | Bowel Changes [ ] Yes [ ]  No | Diapers [ ]  Yes [ ]  No | Diapers night only [ ]  Yes [ ]  No |
| Sleep: Crib [ ]  Yes [ ]  No Bed [ ]  Yes [ ]  No  | Walk [ ]  Yes [ ]  No  | Wheelchair [ ]  Yes [ ]  No  | Crutches [ ]  Yes [ ]  No |
| **Other**  | Vision Problems? (If yes, explain)       | [ ]  | Yes | [ ]  | No |
| Ears, Nose or throat problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Speech Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Hearing Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Dental Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| If child is approved for this program will dental work be taken care of? (If yes, send documentation) | [ ]  | Yes | [ ]  | No |
| Orthopedic Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Respiratory Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Skin Problems? (If yes, explain)      | [ ]  | Yes | [ ]  | No |
| Is your child free of Parasites/lice/worms? (If yes, send documentation)All children/parent/guardian must be free of all the above. Please take prophylactic treatment.  | [ ]  | Yes | [ ]  | No |

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| **FAMILY HEALTH HISTORY**Please write in significant health problems (examples: cancer, eyes, ears, nose, hypertension, diabetes, heart, kidney, gastrointestinal, neurological, respiratory diseases or deceased ) |
|  | Age | Significant Health Problems |  | Age | Significant Health Problems |
| **Father** |     |       | **Children** | [ ]  M[ ]  F |  |       |
| **Mother** |     |       |  | [ ]  M[ ]  F |  |       |
| **Sibling** | [ ]  M[ ]  F |  |       |  | [ ]  M[ ]  F |  |       |
|  | [ ]  M[ ]  F |  |       |  | [ ]  M[ ]  F |  |       |
|  | [ ]  M[ ]  F |  |       | **Grandmother***Maternal* |     |       |
|  | [ ]  M[ ]  F |  |       | **Grandfather***Maternal* |     |       |
|  | [ ]  M[ ]  F |  |       | **Grandmother***Paternal* |     |       |
|  | [ ]  M[ ]  F |  |       | **Grandfather***Paternal* |     |       |

Revised 3/30/16

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| **Who will be financially responsible for** **blood work, Medical Documents, Pictures, Passports AND GUARDIANSHIP Papers?****Name:**  |
| **Address:** |
| **Person Filling out Application:** |
| **Address of person filling out Application:** |
| **I certify that I have read and understood all the questions set forth in this application and the answers I have furnished on this form are true and correct to the best of my knowledge and belief. I understand that any false or misleading statement may result in the permanent refusal of This Application.** **Signature of Person filling out form:****DATE (month-DD-yyyy):**  |
| **I certify that I have read and understood all the questions set forth in this application and the answers I have furnished on this form are true and correct to the best of my knowledge and belief. I understand that any false or misleading statement may result in the permanent refusal of this application. I understand that submitting this application does not automatically entitle the bearer approval to IMPACT WITH HOPE’S- Childen’s Medical rehabilitation Program.** **APPLICANT'S SIGNATURE:****DATE (month-DD-yyyy):**  |