515 MADISON AVENUE, SUITE 1130
NEW YORK, NY 10022
212-838-3029
800-365-1336
OPENHOMES@BONEMARROW.ORG

OPEN HOMES MEDICAL STAYS APPLICATION

Please read the Open Homes Medical Stays Guidelines carefully before completing this form.

PATIENT INFORMATION

Pediatric ☐ Adult ☐ Date of Birth: _________________ Age________ Gender_____________________________________

Preferred Language ☐ English ☐ Spanish ☐ Other: ____

Are you a veteran? ☐ Yes ☐ No

First Name__________________________ Last Name_______________________________ Phone___________________________

Address____ City_______________ State_____________ Zip______________

Email____
Please use your Airbnb email if a registered user

Caregiver's Name ____ Relationship to Patient_________________________________

Phone____ Caregiver's Email_________________________________

Emergency Contact_______________________________ Phone____

Relationship to Patient____________________________

I have reviewed the Bone Marrow & Cancer Foundation's program guidelines and eligibility requirements and grant permission to share my information for the purposes of BMCF programs.

Patient/Guardian Signature____ Date______________________________

AIRBNB HOUSING REQUEST INFORMATION

First-time Airbnb User ☐ Returning Airbnb User ☐ First-time Medical Stays User ☐ Returning Medical Stays User ☐

Housing for: ☐ Patient only ☐ Patient and Caregiver/Family Member(s) ☐ Caregiver/Family Member(s) only

Reservation Booked by: ☐ Patient ☐ Caregiver ☐ Family Member/Friend E-mail:______________________________________

Requested Arrival Date: ____________ Anticipated Departure Date: ____________ Number of Nights Requested: _____________

City/Neighborhood:_________________________________ State:_______________________________ Zip:_________________

Number of Guest(s)________________ Age(s) of Guest(s)_________________ Number of Room(s) Requested: __________________

Number of Mileage to Treatment Center Request ________________

PATIENT TREATMENT

Diagnosis_____________________________________ Date of Diagnosis____________________________________

Type of Cancer Treatment ☐ Chemo ☐ Radiation ☐ BMT ☐ Other-Specify____

Treatments: ☐ Weekly ☐ Daily ☐ Other ____________________ ☐ Inpatient ☐ Outpatient

Treatment Start Date _______________ Treatment End Date________________ Enrolled in a clinical Trial? ☐ Yes ☐ No

Hospital____ Department ____

Physician___________________________ Email____________________________________ Phone___________________________

Nurse______________________________ Email____________________________________ Phone___________________________

Social Worker______________________________ Email_______________________________ Phone__________________________

PATIENT INCOME

Please do not leave any field blank. If a value is zero, write $0.00. Please provide the applicant's most recent IRS Form 1040 and of other family member(s), if he/she has a combined income.

Current Household Income (Annually)___________________________ Current Household Savings______________________________

Expected change in income ___________________________________ Number of household members _________________________

Patient's Insurance____

REFERRAL INFORMATION *PHYSICIAN, NURSE OR SOCIAL WORKER

Name of Referring Professional______________________________________ Title____

Hospital____ Department____

Address____

City____ State_______________________ Zip____________________________

Email____ Phone ____

Signature of Referring Professional ____ Date______________________________

STATEMENT OF NEEDS

Patient's current medical, living, family and financial situation. Please include an additional page or letter if necessary.

____

____

____

____

☐ YES, I would like to receive information on other Bone Marrow & Cancer Foundation's patient financial and support programs.

GENERAL QUESTIONS

Does the patient or caregiver need a wheelchair-accessible room? ☐ Yes ☐ No

Is the patient/caregiver able to navigate stairs ☐ Yes ☐ No

Please list any other relevant special needs ____

Does the patient or care giver have a service animal? ☐ Yes ☐ No

Does the patient or caregiver require pet friendly accommodations? ☐ Yes ☐ No

Does the patient or caregiver require available parking? ☐ Yes ☐ No

Does the patient or caregiver require smoking friendly accommodations? ☐ Yes ☐ No

Would you like to meet the host/family? ☐ Yes ☐ No

Is the patient willing to share their story, so that more hosts and families donate their home? ☐ Yes ☐ No

Does the patient have any infectious diseases or infectious-disease symptoms? ☐ Yes ☐ No

Does the caregiver have any infectious diseases of infectious-disease symptoms? ☐ Yes ☐ No

Has the patient ever been convicted of a crime of violence, domestic violence, a crime against a child, a crime of theft, or a crime involving drugs? ☐ Yes ☐ No

Has the caregiver ever been convicted of a crime of violence, domestic violence, a crime against a child, a crime of theft, or a crime involving drugs? ☐ Yes ☐ No

Is the patient currently on probation or parole? ☐ Yes ☐ No

Is the caregiver currently on probation or parole? ☐ Yes ☐ No

Does the patient have a civil protection order against him/her? ☐ Yes ☐ No

Does the caregiver have a civil protection order against him/her? ☐ yes ☐ No

Is the patient required to register on a state or the National Sex Offender Registry? ☐ Yes ☐ No

Is the caregiver required to register on a state or the National Sex Offender Registry? ☐ Yes ☐ No

If answered YES to any of these questions please explain below:

____

____

____

____

REFERRING PROFESSIONAL'S STATEMENT

As the referring source, I have reviewed the Bone Marrow & Cancer Foundations guideline and eligibility requirements with the patient and attest that all responses are accurately recorded on this form.

____

Referring professionals name (please print)

Signature____ Date______________________________

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OPEN HOMES MEDICAL STAYS GUIDELINES

Please read the Guidelines carefully before completing the application.

ABOUT MEDICAL STAYS

Our program provides free temporary housing to cancer/ transplant patients, caregivers, and donors while receiving lifesaving treatment. Any patient, pediatric or adult, who lives at least 30 miles away from his/her treatment facility is eligible to apply. The Bone Marrow & Cancer Foundation is not liable for any guest's health condition, individual's safety, or personal belongings. Transportation and other associated costs are not provided.

The Bone Marrow & Cancer Foundation's Patient Coordinators will help to locate a housing accommodation that is geographically close to the patient's treatment center.

All patients who are receiving treatment for a cancer diagnosis or still getting post care by a certified cancer center are welcomed to our program. Social worker, nurse, or physician may make a referral by completing the *Bone Marrow & Cancer Foundation Open Home Medical Stays Application.* The referrer may mail or email the application to openhomes@bonemarrow.org

MEDICAL STAYS GUIDELINES

A patient and caregiver may have a maximum medical stays of two weeks, however, an extended stay could be accommodated if medically necessary. Please note, the patient may have to move to a different home.

STATEMENT OF NEEDS

We encourage the referrer to be specific of the needs of the patients as much as possible. When necessary, feel free to attach an additional page.

ELIGIBILITY REQUIREMENTS FOR PATIENTS

- Must live at least 30 miles from treatment center.
- Must be seeking or receiving active cancer treatment.
- Must have a permanent home to return to after treatment.
- Must be at least 18 years of age or accompanied by an adult who is a guardian/caregiver.
- Must be able to care for oneself unless staying with a caregiver.
- Requests for a medical stays must be made by the treatment facility's social worker, nurse, or physician.
- Annual household income should be less than $75,000.

APPLICATION REQUIREMENTS

Referrer, on behalf of patient, may submit the application by mail, or email.
Applicant's current IRS Form 1040 is required.

Applicant will be notified of eligibility 2 weeks from the date of application received by the Bone Marrow & Cancer Foundation.

For question about the Medical Stays or if the patient needs assistance, please contact the Bone Marrow & Cancer Foundation:
www.bonemarrow.org 800-365-1336

The Bone Marrow & Cancer Foundation reserves the right to deviate from these Guidelines on a case-by-case basis when special circumstances arise.