

# BE AN ANGEL

## HELP A CHILD

*Helping Children With Multiple Disabilities or Profound Deafness Since 1986*

*It is our **MISSION** to improve the quality of life for children with multiple disabilities or profound deafness by providing adaptive equipment and select services to individuals and institutions that require a supplement to alternative means of funding.*

Please return every page of this completed form to:

Be An Angel Fund, Inc.  
2003 Aldine Bender  
Houston, Texas 77032

or

Fax to : 281-219-7746

or

Scan and email to : [russ@beanangel.org](mailto:russ@beanangel.org)

All responses must be ***printed legibly in English and all pages returned.***

Incomplete applications will not be considered and returned to applicant for completion.

**This application is for the Be An Angel in-home respite care program called “Alternatives for Angels” only. All other requests must be submitted on the appropriate application.**

Be An Angel has provided funding to meet the needs of special angels since 1986.

If you have any questions, or require assistance please contact our office at 281-219-3313.

Thank you for submitting your request to Be An Angel Fund.

Sincerely,



Russ Massey  
Program Director

## Be An Angel AFA Respite Request Form

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

Have you applied/received assistance from us before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? \_\_\_\_\_

Disabled Child's Name (client) \_\_\_\_\_

Client Date of Birth \_\_\_\_\_ Client SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Client disabilities (list all medical diagnoses) \_\_\_\_\_  
\_\_\_\_\_

School Name \_\_\_\_\_ School District \_\_\_\_\_

Therapist at School: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Any additional medical professionals involved: \_\_\_\_\_

Parent/Legal Guardian Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

State, Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Please list other community agencies, doctors, and foundations that you have contacted about your current need. Provide addresses and/or phone numbers. Attach any denial letters you may have received.

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## PLEASE LIST ALL HOUSEHOLD MEMBERS

Last Name	First Name	Middle Name	Relation to Client	Date of Birth

All information ***must*** be provided in order to receive assistance

Household Resources	Amount per month	Household Expenses	Amount per month
Net Employment Income (Take Home Pay)		Mortgage/Rent/Home Insurance	
Unemployment Income		Electricity	
Child Support		Gas	
Social Security		Water/Sewer	
Food Stamps		Phone: Home/Cell/Internet	
Savings		Cable/Satellite TV	
Housing Assistance		Health Insurance/Medical Bills/Prescriptions	
Other Income		Car Payment/Insurance	
		Childcare	
		Average Food Expense (Groceries/Eating Out)	
		Other Expenses	
<b>Total Monthly Income</b>		<b>Total Monthly Expense</b>	

***Please attach all CURRENT (previous month is preferred) income and expense supporting documents (i.e. W2 or payroll stub, lease agreement, electric bill, phone bill, etc.)***

Have you made this request to Medicaid or to your primary insurance carrier? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please attach their denial letter.

All information provided on this form is true and correct to the best of my knowledge.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

## Alternative for Angels Respite Program Questionnaire

1. Has your child received any at-home respite care in the past 30 days? YES or NO  
If yes... list agency

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2. Has your child received provider service in the past 30days? YES or NO  
(ie.: Person coming into your home to assist with grooming, laundry, cleaning etc.)  
If answer is yes list agency:

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3. Is your child currently on a waiting list for respite service through MHMRA? YES or NO  
If yes, provide name of service coordinator.

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4. Does your child have G-Button, Treac or both? \_\_\_\_\_

5. Does your child have seizures? YES or NO  
If yes, are seizures under control, List medications

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6. When was your child's last doctors' visit? \_\_\_\_\_  
Doctor's name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

6. Childs last TB skin test, please provide shot records.  
Date last TB Skin test \_\_\_\_\_

9. Give all pertinent information about your child's health and challenges.  
Use additional pages as needed.

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**Client Assistance Request Check List**

(Check applicable boxes and Include this form with returned Assistance Request)

Please be sure to provide as much of the following information as possible with your completed assistance form. Feel free to provide any other supporting documentation or letters of support that you deem necessary or helpful.

Letter from parent/guardian explaining why request is being made at this time and what the benefit to your child and family will be.

**Denial Letters**

- Insurance
- Medicaid
- Community Agencies
- Other

**Income Verification**

- Payroll Stubs or W2
- Unemployment Income
- Social Security Disability Payment
- Child Support
- Food Stamps
- Housing Assistance
- Other

**Expense Verification**

- Mortgage or Lease Agreement
- Electric Bill
- Gas Bill
- Water Bill
- Telephone Bill
- Health Insurance Bill
- Automobile Note
- Childcare Expense
- Other Recurring Monthly Payments (provide statements)

## Be An Angel Authorization for Release of Information

Client Name \_\_\_\_\_

Date \_\_\_\_\_

Refusal to provide necessary documentation or to answer an interviewer's questions will disqualify me and my household from assistance.

Any false or misleading information provided in writing or verbally will disqualify me and my household from assistance.

I certify that all information provided to Be An Angel either in writing or verbally is correct and true to the best of my knowledge.

Additionally;

I give permission for Be An Angel staff to verify information by contacting any party I have listed or verbally mentioned in the process of seeking assistance. Any discrepancies between my application information and verification efforts will be provided to me for clarification.

I release Be An Angel from any liability or legal responsibility that may arise from the verification process.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

### MEDIA RELEASE

I give Be An Angel Fund, Inc. the right to interview and/or take photographs, audio or visual-recordings of me/my child to be used in promotional, educational or fundraising materials including, but not limited to videotapes, pamphlets and brochures. I understand my/my child's name may be used in connection with these materials. By signing this media release, I intend to legally bind myself, my minor children, my heirs, executors and administrators. I acknowledge that Be An Angel Fund, Inc. shall have all rights of copyright in and to such photographs and videotapes and may use such copyright fully. I also hereby release Be An Angel Fund, Inc. and its officers, agents and employees from all liability connected with the taking and use of these materials as is authorized by Be An Angel Fund, Inc. In addition, I waive all rights, interest or claims for payment in connection with any exhibition or release of these materials. This consent is voluntary, and I give it in the interest of public information, education, and the furtherance of the goals of Be An Angel Fund, Inc. or other lawful purposes. I acknowledge that I have the legal authority to sign this form on behalf of the minor child whose name is mentioned above.

\_\_\_\_\_  
Parent/Legal Guardian

\_\_\_\_\_  
Date

## Be an Angel Fund, Inc.

### Clients Rights

Clients have a right to all of the services of the agency they qualify for (as long as they follow the guidelines). The services will be provided in the most efficient manner that meets the client's needs.

Each client has the following basic rights:

1. A right to respect, consideration and safety
2. A right to make his/her own life decisions
3. A right to privacy and confidentiality in personal matters
4. A right to discontinue services with Be An Angel at any time
5. A right to any information kept by Be An Angel about him/her, and may review personal records upon request, by established procedures. Each client may record entries in his/her file.

Each client has the following rights in regard to services available:

1. A right to have services available posted for easy access to view them, and to a copy of descriptions of services.
2. A right at the time of intake to have guidelines explained and to sign understanding and consent to follow these guidelines, and to a copy of the guidelines.
3. A right to be informed of Client Grievance Resolution Procedures and to a copy of these procedures.

I have read and understand the above statements regarding my rights as a client.

My signature verifies that the information I have provided the agency is true to the best of my knowledge and may be used to determine my eligibility for the services offered at this agency. Further, I understand that my receiving assistance at this agency is determined by cooperating with the agency staff and fulfilling my responsibilities and obligations.

My signature verifies I have received a copy of the Client Grievance Resolution Form.

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Parent/Legal Guardian

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Date

## **Be An Angel Fund, Inc.**

### **Client Grievance Resolution**

Any client who has a complaint, problem, question, or grievance should immediately bring it to the attention of the program director.

The parties are encouraged to resolve the problem in the most direct fashion, at the most immediate level and in the least complicated manner.

However, if a satisfactory resolution is not received at that level, the client should then promptly take the matter to the next level as follows:

1. Executive Director
2. Be An Angel Board Grievance Committee

If the matter is not resolved at the Executive Director's level, the client should present his/her problem, grievance or complaint, in writing, to the Board Grievance Committee, 2003 Aldine Bender, Houston, Texas 77032. The Committee will investigate the complaint and recommend possible solutions. There is no standing meeting time; the Committee meets on an as needed basis. A written decision by the Committee may be expected within not more than fourteen (14) days from receipt of the written complaint, unless otherwise notified in writing by the Committee.

The client must include a current mailing address and phone number on all correspondence. No decisions will be made or reported via telephone. The decision of the Board Grievance Committee shall be final.



Be An Angel Fund, Inc.  
Hold Harmless Agreement

Whereby I, (full name) \_\_\_\_\_ agree, that should I receive goods and/or services from Be An Angel Fund, Inc. (BAA) as a result of this assistance request, I do so entirely of my own initiative, risk and responsibility. Therefore, in consideration of BAA approving my request and providing requested goods and/or services I do hereby, for myself, all those on behalf of whom I may have made the request, my or their heirs, executors and assigns, release and forever discharge BAA and any of its affiliates, or subsidiaries and all of its officers, agents and employees, acting officially or otherwise, from any and all claims, demands, actions or causes of action on account of my death, or any injury to me or to those on behalf of whom I may have made the request, or my personal property, which may occur from any cause, including negligence of any type. Therefore, neither BAA nor its affiliates or subordinates, officers, agents, and employees shall be or become liable or responsible for any loss, injury, or damage to any person, property, or otherwise in connection with any good and/or service resulting directly or indirectly from any defect in or misapplication of said goods and/or service including any breakdown in machinery or equipment, or for any loss or damage resulting from defective equipment, materials, nutritional products, and that neither BAA nor any of its affiliates or subsidiaries, officers, agents and employees shall be or become liable or responsible for any additional expenses or liability sustained or incurred by recipient of goods and/or services as a result of any of the foregoing causes.

Additionally, I acknowledge that the welfare and safety of any and all of my minor children who might be the beneficiaries of goods and/or services provided by BAA will be my sole responsibility and add my consent on their behalf that all stipulations and contingencies as stated above are applicable to them as well.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date