



Meadows  
OF  
Hope  
RESTORING HOPE. TRANSFORMING LIVES.

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1226 Silver Spring Road, Holtwood, PA 17532  
Phone: 717-284-2019 Fax: 717-284-2852

## Parent/Guardian – Application for Admission

Thank you for your interest in applying to Meadows of Hope.  
Please read all the information carefully, including this brief introduction.

**Ministry Theme Verse** - "This hope we have as an anchor of the soul, both sure and steadfast. It leads us through the curtain into God's inner sanctuary" (Heb. 6:19).

**Vision** - Meadows of Hope exists to disciple teen girls into a healthy relationship with God and others and responsible life choices.

**Mission** - Meadows of Hope offers hope and redemption through a family environment, equine assisted learning, and individual counseling.

### Focus of ministry:

- In partnership with Camp Andrews in their ministry to youth, we at Meadows of Hope serve teen girls who are struggling socially, emotionally, and spiritually.
- We serve girls between the ages of 13-20.
- The teen girls who enter our program are not mandated to come to MOH; we help teen girls who are aware of their need to make a change, and who are willing to work on their problems.

### Core Values:

- Developing relationship with the Triune God as revealed in Scripture
- Partnering with sending ministries
- Fostering responsible stewardship of resources
- Honoring the unique and intrinsic value of each person
- Providing a nurturing environment

### Commitment:

- This application assists us in determining if we can meet your specific need for help. If for some reason we cannot, we may be able to refer you to another organization or ministry.
- Applicants to Meadows of Hope should have a desire to receive help in a Christian environment and should be willing to apply the principles of a biblical discipleship program.
- Teen girls applying to Meadows of Hope cannot be placed involuntarily by parents/guardians and must desire change in their life. The desire for personal change plays a significant part in the healing process while at Meadows of Hope. Applicants accepted to Meadows of Hope will be asked to sign a *Commitment to Change* contract prior to entry.
- Generous individuals and businesses give to Meadows of Hope which keeps program fees low and reasonable for each teen entering the program. As stewards of these gifts and to be accountable to our donors, we want to ensure that each bed is filled with a teen who wants help and who is willing to work through the program.
- If your teen decides to leave the program prematurely or is discharged due to not complying with expectations, she will need to wait for a period of time before starting the application process again, as per the discretion of the staff of Meadows of Hope.

### Directions:

- The teen applicant must be between the ages of 13-20.
- Please type or print clearly with dark colored ink.
- For questions, email Jenni Wagler at [jenni@meadowsofhope.org](mailto:jenni@meadowsofhope.org) or call Jenni at 717-284-2019.

- Send completed application (and all related information) to:  
**Meadows of Hope, 1226 Silver Spring Road, Holtwood, PA 17532**

**Processing Procedure:**

Upon receipt of your application, your daughter’s application, and the supporting ministries application, we will review them and confirm that Meadows of Hope is a viable placement option for your daughter. You will then be contacted to set up an on-site visit. At the on-site visit, a decision will be made by the Meadows of Hope staff as to whether or not we would offer your family a placement opportunity.

**Today’s Date:** \_\_\_\_\_

**General Information:**

- Applicant’s Full Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  
 City, State/Province, and County of Birth: \_\_\_\_\_  
 U.S. Citizen Yes No If no, explain: \_\_\_\_\_
- Name of person filling out this application: \_\_\_\_\_ (circle one) Father Mother
- How have you heard about Meadows of Hope? (check all that apply)  
 Church (if checked, give the church name) \_\_\_\_\_  
 Internet Counselor Friend Other (explain) \_\_\_\_\_
- Have you ever applied to Meadow of Hope in the past? Yes No If yes, provide approximate date: \_\_\_\_\_  
 Has your child ever been a resident at Meadows of Hope? Yes No If yes, provide approximate date: \_\_\_\_\_
- Child’s Ethnicity: African American Asian Caucasian Hispanic Native American  
 Other (specify) \_\_\_\_\_
- Does your child want help? Yes No Sometimes
- Who is the child’s legal guardian(s)?  
 Name(s) \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_
- Emergency contact information in case of emergency: Person’s Name \_\_\_\_\_  
 Address \_\_\_\_\_ Home # \_\_\_\_\_  
 \_\_\_\_\_ Work # \_\_\_\_\_  
 \_\_\_\_\_ Cell # \_\_\_\_\_

**Parent of Child in Current Household:**

- Father’s Name \_\_\_\_\_ (circle one) Biological Adoptive Step-parent  
 Address \_\_\_\_\_  
 Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Email Address \_\_\_\_\_ Occupation \_\_\_\_\_
- Mother’s Name \_\_\_\_\_ (circle one) Biological Adoptive Step-parent  
 Address \_\_\_\_\_  
 Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
 Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

11. Name and ages of other biological, adoptive, or foster children in your current household:

Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster

12. Name and ages of other biological, adoptive, or foster children **NOT** in your household:

Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster
Name _____	Age _____	Biological	Adoptive	Foster

13. Name and ages of other biological siblings or step-siblings of your adopted teen girl:

Name _____	Age _____	Biological	Step-sibling
Name _____	Age _____	Biological	Step-sibling
Name _____	Age _____	Biological	Step-sibling
Name _____	Age _____	Biological	Step-sibling
Name _____	Age _____	Biological	Step-sibling

**Parent of Child NOT in Current Household:**

14. Father's Name \_\_\_\_\_ (circle one) Biological Adoptive Step-parent

Address \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

15. Mother's Name \_\_\_\_\_ (circle one) Biological Adoptive Step-parent

Address \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Occupation \_\_\_\_\_

16. Please provide any helpful details you know about child's biological parents & family; e.g. abusive, addictions, neglectful, mental health challenges, extremely poor, etc. etc. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please answer the questions below about the parents or guardians, either biological or adoptive, who have been involved in raising the child:**

17. If Father is deceased, give age at time of death, how old the child was, and cause of death: \_\_\_\_\_

18. Briefly describe child's relationship with her dad: \_\_\_\_\_

19. If Mother is deceased, give age at time of death, how old the child was, and cause of death: \_\_\_\_\_

20. Briefly describe child's relationship with her Mother: \_\_\_\_\_

21. Please circle the word or phrase below that best describes the marital status of the child's parents:

Never married    Married to each other    Divorced    Re-married

**Personal History**

22. Was your child adopted?    Yes    No    If yes, age adopted: \_\_\_\_\_

If yes, specifically describe the circumstances that led to your daughter being placed into your home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been placed in a foster care home?    Yes    No

If yes, explain how many foster homes, length in each one, ages, conditions, etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Has your child ever been in a treatment program (residential or non-residential)    Yes    No

Where? \_\_\_\_\_ Dates: \_\_\_\_\_

Why? \_\_\_\_\_

24. Has your child ever tried to commit suicide?    Yes    No    When? \_\_\_\_\_ How? \_\_\_\_\_

25. How often would you say your child thinks about committing suicide? \_\_\_\_\_

26. Has your child ever self harmed?    Yes    No    How? \_\_\_\_\_

At what age did she start and is this a current struggle? \_\_\_\_\_

27. Has your child ever been a victim of rape?    Yes    No    What age? \_\_\_\_\_

28. Has your child ever been the victim of sexual abuse?    Yes    No    What age? \_\_\_\_\_

29. Has your child ever been the victim of physical abuse?    Yes    No    What age? \_\_\_\_\_

30. Has your child ever been involved in prostitution?    Yes    No

31. Has your child ever been involved in sex trafficking?    Yes    No

32. Has your child ever experienced a significant amount of confusion about her sexuality?    Yes    No

**Legal Background:**

33. Has your child ever been arrested?    Yes    No    How many times? \_\_\_\_\_ Dates/charges/etc. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

34. Does your child have any pending court dates?    Yes    No    Explain: \_\_\_\_\_

35. Is your child currently on probation?    Yes    No    If so, how long and time remaining: \_\_\_\_\_

36. Is your child currently on parole?    Yes    No    If so, how long and time remaining: \_\_\_\_\_

**Substance Abuse:**

37. Check any substances with which your child has experimented:

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Alcohol                       | <input type="checkbox"/> Hallucinogenic (acid, LSD, etc.) | <input type="checkbox"/> Opium        |
| <input type="checkbox"/> Amphetamines (uppers)         | <input type="checkbox"/> Crack                            | <input type="checkbox"/> Heroin       |
| <input type="checkbox"/> Barbiturates (downers)        | <input type="checkbox"/> Crystal Meth                     | <input type="checkbox"/> Ecstasy      |
| <input type="checkbox"/> Cocaine                       | <input type="checkbox"/> Marijuana                        | <input type="checkbox"/> Tobacco      |
| <input type="checkbox"/> Crack                         | <input type="checkbox"/> Methamphetamines                 | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Inhalants (glue, paint, etc.) | <input type="checkbox"/> Morphine                         |                                       |

**Medical:**

38. Height \_\_\_\_\_ Weight \_\_\_\_\_

39. Check the general state of your child's health:    Excellent    Good    Average    Poor

40. Are there any known medical problems that run in the biological family of the teen? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

41. Were there any issues by the teen's biological mother during her pregnancy with the teen? \_\_\_\_\_  
\_\_\_\_\_

42. Were there previous and are there current illnesses of the teen: \_\_\_\_\_  
\_\_\_\_\_

43. Were there previous and are there any current sustained injuries of the teen: \_\_\_\_\_

44. Were there previous and are there current dental problems of the teen: \_\_\_\_\_  
\_\_\_\_\_

45. Were there previous and are there any current mental health problems of the teen. If so, list the source of the diagnosis: \_\_\_\_\_  
\_\_\_\_\_

46. Are there any body stimulation and/or movement stimulation processes and procedures needed for your teen for any disability: \_\_\_\_\_  
\_\_\_\_\_

47. Are there any necessary ongoing medical care needs for your teen: \_\_\_\_\_  
\_\_\_\_\_

48. Does your child have any allergies? (food, medicine, animals)    Yes    No  
List all known allergies: \_\_\_\_\_

Does she require an EpiPen?    Yes    No

49. List any and all medication or supplements that your child currently takes:

Medication/Supplement	Dosage	Reason	For How Long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

50. Please list any dietary/eating restrictions/limitations your child has: \_\_\_\_\_

Were these restrictions recommended by a Doctor? Yes No

51. Does she have, or has she had, a problem with food or eating? Yes No If yes, explain: \_\_\_\_\_

Have your child been diagnosed or treated by a Doctor for an eating disorder? Yes No

If yes, please provide the doctor's name and telephone #: \_\_\_\_\_

52. To the best of your knowledge, is your child sexually active now? Yes No

53. Are all immunizations current? Yes No If no, explain: \_\_\_\_\_

54. Your child's current family **doctor**: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your child's current **therapist/counselor**: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Your child's current **Psychologist**: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your child's current **Psychiatrist**: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

55. List all past surgeries or medical hospitalizations (include hospital name, approx. dates, reasons for hospitalization, and outcome): \_\_\_\_\_

**Counseling and Treatment:**

56. Has your child ever been diagnosed or treated for: (check all that apply)

- ADD/ADHD
- Anxiety
- Asperger's Syndrome
- Bipolar Disorder
- Borderline Personality
- Depression
- Dissociative Identity Disorder
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Post Traumatic Stress Disorder
- Reactive Attachment Disorder
- Schizophrenia

Has your child been in any counseling therapy in the last two years e.g. therapist, psychiatrist, psychologist, rehabilitation center, detoxification program, etc.? Yes No If yes, please list the counselors below

1) Date of Entry: \_\_\_\_\_ Counselor/Place: \_\_\_\_\_  
City/State: \_\_\_\_\_ Reason for going: \_\_\_\_\_  
Discharge date: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

2) Date of Entry: \_\_\_\_\_ Counselor/Place: \_\_\_\_\_  
City/State: \_\_\_\_\_ Reason for going: \_\_\_\_\_  
Discharge date: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

3) Date of Entry: \_\_\_\_\_ Counselor/Place: \_\_\_\_\_  
City/State: \_\_\_\_\_ Reason for going: \_\_\_\_\_  
Discharge date: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_

57. Has your family ever been in any counseling e.g. marriage counseling, family counseling, etc? Yes No

Approximate Dates: \_\_\_\_\_

**Education:**

58. Is your child currently in school?  Yes  No

59. If yes, what type of school does she attend?  Public  Private  Home School  Residential School

60. If yes, what is her class size?  Small (less than 15)  Medium (15-25)  Large (more than 26)

61. If yes, check off any of the following that apply to her within the last two years:

General Lecture/Classes    Honors/Gifted    Resource Center    Self-Paced/Individualized    Special Education

62. List child's current classes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

63. Check the last grade she completed:  6<sup>th</sup>  7<sup>th</sup>  8<sup>th</sup>  9<sup>th</sup>  10<sup>th</sup>  11<sup>th</sup>  12<sup>th</sup>  1<sup>st</sup> Year College  2<sup>nd</sup> Year College

64. Name the last school attended: \_\_\_\_\_

65. Give address of this school: \_\_\_\_\_

66. Dates she attended this school: \_\_\_\_\_

67. Check any of these that your child has experienced:    Suspension    Expulsion    Repeated Grade(s): \_\_\_\_\_

68. Check the total number of schools your child has attended:    1-2    3-4    5-6    Other  
Please explain: \_\_\_\_\_

69. List any extra-curricular activities and/or sports your child has been involved in the last two years: \_\_\_\_\_  
\_\_\_\_\_

70. List any education-related challenges your child has (learning disabilities, reading comprehension, dyslexia, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

**Supporting Ministry/Church Involvement:**

71. What is the name of the ministry or church with whom your child is connected? \_\_\_\_\_

72. What has been her involvement with the ministry/church? \_\_\_\_\_  
\_\_\_\_\_

73. What has been your involvement with the ministry/church? \_\_\_\_\_  
\_\_\_\_\_

74. Who will commit to being an older female mentor for your child before, during, and after she completes the program at Meadows of Hope? \_\_\_\_\_

75. Who is the person in this ministry/church from whom your child receives the most input? \_\_\_\_\_  
\_\_\_\_\_

76. Which specific activities is your child involved in with this ministry? \_\_\_\_\_

77. How long has she been involved in this ministry? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Personal/Spiritual Questions:**

78. Check those that apply to your child (personality/character strengths):

- |  |  |
|--|--|
| <input type="checkbox"/> Shows insight into her problems               | <input type="checkbox"/> Shows remorse for bad behavior      |
| <input type="checkbox"/> Creative                                      | <input type="checkbox"/> Honest                              |
| <input type="checkbox"/> Sense of Humor                                | <input type="checkbox"/> Strong Conscience                   |
| <input type="checkbox"/> Leadership potential                          | <input type="checkbox"/> Listens to others                   |
| <input type="checkbox"/> Good health                                   | <input type="checkbox"/> Accepts constructive criticism well |
| <input type="checkbox"/> Works hard at tasks                           | <input type="checkbox"/> Expresses thankfulness              |
| <input type="checkbox"/> Energetic                                     | <input type="checkbox"/> Has strong church support system    |
| <input type="checkbox"/> Intelligent                                   | <input type="checkbox"/> Displays perseverance               |
| <input type="checkbox"/> Athletic                                      | <input type="checkbox"/> Displays courage                    |
| <input type="checkbox"/> Has a personal relationship with Jesus Christ | <input type="checkbox"/> Has personal goals                  |
| <input type="checkbox"/> Compassionate                                 | <input type="checkbox"/> Connected to the family             |
| <input type="checkbox"/> Expresses feelings/emotions                   | <input type="checkbox"/> Likes herself                       |
| <input type="checkbox"/> Organized                                     | <input type="checkbox"/> Responds to authority               |

Any other comments about your child's personality/character strengths: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

79. Describe how this child has been disciplined: \_\_\_\_\_  
\_\_\_\_\_

80. Explain the kind of relationship the child has with her brothers and sisters: \_\_\_\_\_  
\_\_\_\_\_

81. Describe your child's electronic media experiences in the last six months (TV, videos, video games, smartphone, internet, etc.)  
e.g. which ones, how often, with who? \_\_\_\_\_  
\_\_\_\_\_

82. Has your child ever committed her life to Jesus Christ?    Yes    No    Date: \_\_\_\_\_    Place: \_\_\_\_\_

83. In what denomination was your child raised? \_\_\_\_\_

84. Has your child ever witnessed or been involved in occult activities?    Yes    No  
If yes, write out a detailed explanation of the involvement with the occult: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

85. Describe the most important behavior issue you would like to see addressed regarding your child?  
\_\_\_\_\_  
\_\_\_\_\_

When did these behaviors begin? \_\_\_\_\_

Please list any other concerns: \_\_\_\_\_

86. Check those that apply and provide a brief explanation for the checked ones  
 Chronically lies \_\_\_\_\_  
 Uses alcohol \_\_\_\_\_



- \_\_\_ Steals \_\_\_\_\_
- \_\_\_ Harms property \_\_\_\_\_
- \_\_\_ Smokes \_\_\_\_\_
- \_\_\_ Sets Fires (when last time?) \_\_\_\_\_
- \_\_\_ Has temper Tantrums \_\_\_\_\_
- \_\_\_ Stuffs her feelings \_\_\_\_\_
- \_\_\_ Is violent to others (when last time?) \_\_\_\_\_
- \_\_\_ Self-mutilates (when last time?) \_\_\_\_\_
- \_\_\_ Is sexually active (with males or females) \_\_\_\_\_
- \_\_\_ Cross-dresses \_\_\_\_\_
- \_\_\_ Exhibits depressed behavior \_\_\_\_\_
- \_\_\_ Runs away from home/school (when last time?) \_\_\_\_\_  
How many times? \_\_\_\_\_ How long? \_\_\_\_\_ With others? \_\_\_\_\_ Where to? \_\_\_\_\_
- \_\_\_ Is involved in the Occult \_\_\_\_\_
- \_\_\_ Has weight problems \_\_\_\_\_
- \_\_\_ Views pornography (by what means?) \_\_\_\_\_
- \_\_\_ Is involved with police or legal system \_\_\_\_\_
- \_\_\_ Talks about or threatens suicide (when last time?) \_\_\_\_\_
- \_\_\_ Attempted suicide (when last time?) \_\_\_\_\_
- \_\_\_ Has difficulty getting along w/ authority \_\_\_\_\_
- \_\_\_ Has friends who are a bad influence \_\_\_\_\_
- \_\_\_ Has a history of abuse: Sexual, physical, emotional (specify victim OR offender, last known time) \_\_\_\_\_

87. What do you most like about your child? \_\_\_\_\_

88. What do you like least about your child? \_\_\_\_\_

89. How do you hope Meadows of Hope will be able to help your child? \_\_\_\_\_

90. How do you hope Meadows of Hope will be able to help your family? \_\_\_\_\_

### Parent/Guardian Commitment

- **Intake.** Helping to fill out applications and realizing the need for their teen girl to enroll in a residential program.
- **Financial.** Contributing financially to the tuition and fees for your teen girl's stay at MOH. Be willing to disclose income tax return from previous year for the MOH education scholarship program.
- **Church Attendance.** Getting plugged in to a good Bible-believing Christian church.
- **Appointments.** Ensuring that your teen girl gets mandated medical and dental visits during home visits. Supply needed medications for your teen girl.
- **Letters.** Sending mail at least once/week to your teen girl.
- **Phone Calls.** Making a phone call once/week to your teen girl.
- **Program Structure.** Supporting the MOH program structure and approach (eg. dress code, menu, church attendance, etc).
- **Equine sessions.** Attending equine/counseling sessions as requested by MOH.
- **Counseling.** Participating in individual and/or family counseling as recommended by MOH.
- **Home Visits.** Supporting and enforcing the MOH home visit guidelines and expectations.
- **Clothing and Accessories.** Purchase the required items for your teen girl.
- **Parent seminars.** Attending parents seminars every 6-8 weeks.
- **Grace and Truth.** Giving encouragement to your teen girl as she works hard at MOH. Meanwhile, maintaining firm boundaries in regards to rules and expectations.
- **Teamwork.** Collaborate and communicate openly with MOH, your supporting ministry representative, and your home mentor.
- **Confidentiality.** Maintain confidential information about other teen girls and their families (trauma, history, diagnoses, family stress). Do not spread information that you hear from your teen girl or learn during parent seminars.
- **Program Length.** If your teen girl wants to quit the program early, parents are committed to collaboration with MOH to arrive at the best decision regarding an early discharge.
- **Graduation.** Assisting in the decision regarding the teen girl's readiness to come home.

Upon receipt of all three applications (mentioned on page 2), if Meadows of Hope staff determines that this child is a viable placement option, the next step in the intake process is an on-site visit. During this visit, Meadows of Hope provides diagnostic assessments of behavioral problems and needs in an interview. In addition, there is an analysis of educational needs in order to assess potential entry level into Meadows of Hope Christian School. Therefore, it is essential that the parent(s)/guardian(s) and the applicant participate in the interview process. By signing this application, I agree to participate in the interview that will be part of the on-site visit and to provide all necessary information which may assist the Meadows of Hope staff in the intake process. I understand that this signature does not obligate this child to enter the program.

#### Before You Send the Application to Meadows of Hope - Check off List:

- Completed application with signature(s) of parent(s)/guardian(s)
- Application Fee of \$125.00 (application will not be processed without receipt of this fee)
- Authorization of Release of Information form for the Supporting Ministry/Church
- Detailed Behavior history
- Court Documentation of guardianship (if you are a court-ordered legal guardian) if requested
- Counseling summaries and/or evaluations
- Recent IEP (Individual Education Plan) if one exists for your child
- Any other information that would help us make an adequate assessment of your child

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Signature

Signature

---

Relationship to Applicant

Date

Relationship to Applicant

Date

# Meadows of Hope

## RELEASE OF INFORMATION FORM (For Minor Age Applicants)

Note: Parent/Guardian does not need to fill this out if applicant is an adult (older than 17)

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of Meadows of Hope. Information regarding such matters cannot be given without the written consent of the applicant's parent/guardian.

Name of applicant \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, do hereby give permission for Meadows of Hope to share information related to my child's application and program records with:

(for example, you may want to include certain family members, ministry/church personnel, etc.)  
(please include contact information, including addresses)

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

This release will expire on (date) \_\_\_\_\_ unless written notification by the applicant's parent/guardian indicates otherwise.

\_\_\_\_\_  
Father/Guardian (Signature) \_\_\_\_\_ Date

\_\_\_\_\_  
Mother/Guardian (Signature) \_\_\_\_\_ Date

\_\_\_\_\_  
Meadows of Hope Representative (Signature) \_\_\_\_\_ Date

*Meadows of Hope*

**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Parent/Guardian SHOULD NOT fill this out if applicant is an adult (older than 17)

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of Meadows of Hope. Information regarding such matters cannot be given without the written consent of the applicant or applicant's parent/guardian.

Applicant/Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I, \_\_\_\_\_, the legal parent or guardian (or the student if 18 or older), of \_\_\_\_\_ (Student) hereby authorize Meadows of Hope and the below named person/ organization to exchange the Student's (set forth above) medical and clinical information relating to dates of treatment, medical, psychological, social, psychiatric, substance abuse diagnoses, treatments, prognosis, counseling, and/or therapy herein contained in the student's medical records.

(please include names, facilities, contact information, including addresses)

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

Please release the following information for the approximate Date(s) of Service: \_\_\_\_\_

- |  |                                   |
|--|-----------------------------------|
| Medical Records and information  | Medication Administration Records |
| Personal history information   | Consultation Reports              |
| Educational information and records  | Laboratory/Radiological Reports   |
| Psychological records, psychiatric records, discharge summaries, treatment records and summaries, counseling records, etc. |                                   |
| Other _____  |                                   |

PLEASE FAX ALL REQUESTED RECORDS TO 717-284-2852 ATTN: ADMISSIONS COORDINATOR

Or scan and email to: [jenni@meadowsofhope.org](mailto:jenni@meadowsofhope.org)

Mailing Address: 1226 Silver Spring Road, Holtwood, PA 17532

I understand the following:

- There may be charges for the copies of my health records due to procedural and regulated steps involved in the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management-Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. The authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative/guardian or I received a copy of this document which I have read. I understand the content of this authorization and voluntarily consent to the release of the information.

---

Applicant/Student (Signature)

---

Date

---

Father/Guardian (Signature)

---

Date

---

Mother/Guardian (Signature)

---

Date

---

Meadows of Hope Representative (Signature)

---

Date

# Meadows of Hope

## SCHOOL RECORDS RELEASE (For Minor Age Applicants)

Note: Parent/Guardian does not need to fill this out if applicant is an adult (older than 17)

All matters relating to applicant records and information are considered confidential and are treated as such by the staff of Meadows of Hope. Information regarding such matters cannot be given without the written consent of the applicant's parent/guardian.

	Requesting School	Sending School
School	Meadows of Hope Christian School Attn: Admissions Dept.	
Street Address	1226 Silver Spring Road	
City	Holtwood	
State, Zip Code	PA 17532	
Phone Number	717-284-2019	
Fax Number	717-284-2852	

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SSN

Does this student have an active IEP?    Yes    No

Meadows of Hope Christian School hereby requests the release of education records for the student identified above who recently enrolled in Meadows of Hope Christian School in the \_\_\_\_\_ grade. I hereby request the release of the following school records to be sent to Meadows of Hope:

Middle School Report Card    Transcript    Withdrawal Grades    Special Education Records  
Any additional information which would be of assistance in placing this student

\_\_\_\_\_  
Father/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Meadows of Hope Representative (Signature)

\_\_\_\_\_  
Date

## *Meadows of Hope*

### RELEASE OF INSURANCE INFORMATION FORM (For Minor Age Applicants)

Note: Parent/Guardian does not need to fill this out if applicant is an adult (older than 17)

In the event that the insurance does not cover the total cost of the Medical bills, I am fully aware that I/We are responsible to pay for anything that insurance does not cover e.g. co-pays, deductible, etc.

I/We, hereby authorize Meadows of Hope to access our Medical coverage for the Student and furnish our/my designated Medical insurance carrier all information regarding the current medical condition, illness or injury of the Student. Meadows of Hope will use the following insurance information when health care services are needed:

Medical Insurance Information:

Resident SSN		
<b>Primary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		
<b>Secondary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		

\_\_\_\_\_  
Father/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Meadows of Hope Representative (Signature)

\_\_\_\_\_  
Date

## *Meadows of Hope*

### RELEASE OF INSURANCE INFORMATION FORM (For Minor Age Applicants)

Note: Parent/Guardian does not need to fill this out if applicant is an adult (older than 17)

In the event that the insurance does not cover the total cost of the Dental/Vision bills, I am fully aware that I/We are responsible to pay for anything that insurance does not cover e.g. co-pays, deductible, etc.

I/We, hereby authorize Meadows of Hope to access our dental/vision coverage for the Student and furnish our/my designated dental/vision insurance carrier all information regarding the current medical condition, illness or injury of the Student. Meadows of Hope will use the following insurance information when health care services are needed:

Dental/Vision Insurance Information:

Resident SSN		
<b>Primary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		
<b>Secondary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		

\_\_\_\_\_  
Father/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Guardian (Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Meadows of Hope Representative (Signature)

\_\_\_\_\_  
Date



## *Meadows of Hope*

### RELEASE OF INSURANCE INFORMATION FORM (For Minor Age Applicants)

Note: Parent/Guardian does not need to fill this out if applicant is an adult (older than 17)

In the event that the insurance does not cover the total cost of the Prescriptions bills, I am fully aware that I/We are responsible to pay for anything that insurance does not cover e.g. co-pays, deductible, etc.

I/We, hereby authorize Meadows of Hope to access our prescription coverage for the Student and furnish our/my designated prescription insurance carrier all information regarding the current medical condition, illness or injury of the Student. Meadows of Hope will use the following insurance information when health care services are needed:

Prescription Medication Insurance:

Resident SSN		
<b>Primary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		
<b>Secondary Insurance Company</b>		
Insured's Name		
Insured SSN		
Insured DOB		
Employer Name and Address		
Group/Policy #	Group#	Policy#
Phone Number (Insurance)		

\_\_\_\_\_ Date

\_\_\_\_\_ Date

\_\_\_\_\_ Date