



Application for Grief Services

Or complete online: HospiceGriefServices.com

STAFF ONLY:
 Archive Date: _____
 Documentation: Cres / Netsmrt: H / Com
 Scanned Docs: App / SOU / Releases
 Site Location: NK / R / S / SV / C / Sch
 Peds Services: CE / WR: R / S / SV / Sc

Adult's Full Name		Date of Birth	
Phone Number(s)		Ethnicity	
Mailing Address		Marital Status	
City, State & Zip			
Email Address			

If you are applying for Camp Erin, Wave Riders, or other services for children, please complete this section:

Child's First Name	Child's Last Name	Date of Birth	Age	Identified Gender	Who died? The child's...

Are you the legal guardian of the children?	Yes / No	Relationship? You are the child's...	
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Who died? (First & Last Name)		Relationship? They were your...	
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How did they die?		Date of death:	
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Was the person who died a Hospice patient?	Y / N	Preferred Support	Preferred Site
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Is your household considered low income? (Less than \$36,900 a year)	Y / N	<input type="checkbox"/> I'm not sure	<input type="checkbox"/> Albany - NK
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Anyone in your household a veteran? If yes, please list branch of service:		<input type="checkbox"/> Counseling	<input type="checkbox"/> Rensselaer
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How did you hear about our services?		<input type="checkbox"/> Support Groups	<input type="checkbox"/> Sunnyview Hosp
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Date/Time:	Notes: (for staff only)	Additional Information: Reasons for seeking support, additional losses, medical or physical concerns.
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