

Hope House Reservation Request Form Houston's First Baptist Church

Date rcvd in Office: _____

**Check in and out for Hope House Guests is done during Pastoral Care office hours--- Monday through Friday, 8:00 am to 5:00 pm. Weekends are reserved for family and worship. **

Patient's Name: _____

Dates Requested for Stay: _____

Arrival _____ Departure _____ Length of Stay _____ Days

******Requested Dates are subject to approval and availability. There is a minimum stay of two weeks.**

PLEASE INCLUDE A PHOTO OF PATIENT AND SPOUSE OR CAREGIVER

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

HFBC Contact: _____

How did you hear about the Hope House? _____

Brief description of diagnosis: _____

Church Membership: _____

Senior Pastor's Name: _____ Church Phone: _____

Church Address: _____ City: _____ State: _____ Zip: _____

Hospital of Treatment: _____ Patient ID: _____

Name of Social Worker: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Primary Caregiver Staying with Patient: (This person will serve as the Houston Emergency Contact.)

Criminal Background check required (Please submit completed Waiver Form)

Name: _____ Relationship: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Additional Caregivers/Guests Staying with Patient: Criminal Background check required (Please submit completed Waiver Form)

Name: _____ Relationship: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Name: _____ Relationship: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Name: _____ Relationship: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Emergency Contact: (Other than a local caregiver---someone at home)

Name: _____ Relationship: _____

Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

Please submit all Hope House Application Forms to

HopeHouse@HoustonsFirst.org