Healing hope Ministries Registration Form

Please fill in the following application completely and be assured that all the information you give us will remain confidential and is being used solely for informational purposes. Please indicate your preferred dates of stay below. You may select any number of nights with a ***minimum of two nights to a maximum of four nights.*** We have found it beneficial if couples and/or families can stay for 3-4 nights but realize that schedules don't always allow this amount of time. ***The cost for staying is just $50.00 per night.*** We look forward to welcoming you and hope it will be a haven that allows you and your family to relax, reconnect and continue your healing journey. ***Once your registration form is completed simply send it, along with your first night's non-refundable deposit ($50) in the mail to Healing Hope Ministries, 31085 475th Ave, Alcester, SD 57001.*** We will contact you as soon as we receive it to confirm the dates.

Dates you would like to come: _____

PLEASE NOTE: Registrations are held on a first-come, first-serve basis. You may want to call ahead of time to see if your dates are available.

Name of person completing this registration: _____

Person who referred you to Healing Hope Ministries: _____

Please share the name of your child that has died: _____ Date of Birth: _____

Cause of death: _____ Age at time of death: _____ Date of Death: _____

Family members who will be staying at Healing Hope Ministries include:

Mother's name: First: _____ Last: _____

Father's name: First: _____ Last: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone # _____ Cell Phone # _____

Email Address: _____

Name(s) and Age(s) of all other children who will be coming with you to Healing Hope:

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Name: _____ Relationship: _____ Age: _____

Emergency Contacts - in case of an emergency while you are staying with us.

Name: _____ Cell phone # _____

Home phone # _____ Work phone # _____

Name: _____ Cell phone # _____

Home phone # _____ Work phone # _____

Please share with us who or what has helped you and your family since your child's death—and in what ways?

_____

_____

Describe any specific concerns that you or your spouse/partner have relating to your grief process and your healing journey.

_____

_____

Describe any specific concerns that your may have relating to your surviving children and any concerns that you have heard them express relating to their sibling's death:

_____

_____

How would you describe your family's communication regarding the death of your child since their death? ____ Open ____ Adequate ____ Very Little ____ Avoided ____ None ____ Desire more

Does anyone in your family have any health problems or allergies that we should be aware of? If so, please explain.

_____

Is anyone in your family currently taking any prescription medications? If so, please list the name of the medication and the person taking it. Again, this is strictly confidential.

_____

Please tell us about your special interests of hobbies.

Mother: _____

Father: _____

What are your expectations or hopes for your stay at Healing Hope?

_____

_____

_____

Once again—ALL information is confidential. Healing Hope Ministries is a smoke-free and alcohol free facility. Thank you for your understanding. I/we understand and recognize that staying at Healing Hope is contingent on reception and approval of this registration as well as compliance with all conditions, qualifications, and restrictions designated by Healing Hope Ministries.

Signature: _____ **Date**: _____

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