Jewish Caring Network
The Tikva House

Form Must Be Filled Out Completely and Signed in Order to Finalize Your Reservation:

Patient Information:

Housing Application Date: _____

Patient's Name:

_____

(Title) (First) (Middle) (Last)

Date of Birth: _____ Gender: _____ Age: _____

Home Address_____

City: _____ State: _____ Zip Code: _____

Cell: _____ Home Phone: _____

Email: _____

- Hospital: □ Johns Hopkins □ Johns Hopkins (Bayview) □ Kennedy Krieger □ Sheppard Pratt □ Other_____
- Reason for visiting hospital: □ Outpatient Appt(s) Dates: _____ _____ _____
  □ In-patient Appts. □ Surgery □ Transplant □ Other_____
- Needs/Requirements: □ Handicap Accessible Room □ Other_____
- Would you like your name added to the JCN Tehillim List? □ Yes □ No
- Patient's Hebrew Name: _____
- Will you need an interpreter? □ Yes □ No What language do you speak? _____
- Would you like to be visited in the hospital? □ Yes □ No
- Would you like to speak with a Rabbi or Chaplain? □ Yes □ No

Attending Physician: _____

Physician's Phone #: _____ Email: _____

Hospital's Social Worker's Name: _____ Email: _____

Patient's Arrival Date - Hospital: _____ **Approx. Check in time:** _____

Guest's Arrival Date – Tikva House: _____ **Approx. Check in time** _____

Guest's Anticipated Departure Date: _____ **Approx. Check out time:** _____

If Patient is a Minor:

Mother's Name: _____ Cell: _____

Email: _____

Father's Name: _____ Cell: _____

Email: _____

□ Legal Guardian □ Caretaker (if other than parents) Name: _____

Cell: _____ Email: _____

To provide the best service possible to our guest(s), we often partner with other agencies, organizations, and entities. This authorization grants us permission to speak with and release/obtain information from them. I grant permission for the Jewish Caring Network – Gevuras Yarden, Inc. to obtain and/or provide information from/to my healthcare providers and the organizations and entities from which I receive services. I am aware that I am not obligated to release this information. I understand that this authorization may be withdrawn by me at any time, in writing, except to the extent that action has already been taken in reliance upon it. This authorization will expire upon termination of services.

Patient's Name: _____ Date: _____

Patient's Signature: _____ Date: _____

Name of Patient (Minor): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Guest Information:

- Please List the Names of **ALL** Other Family Members Planning to Stay in the Tikva House.
- IF NAMES ARE NOT PROVIDED BELOW, INDIVIDUALS ARE **NOT** PERMITTED TO STAY IN THE TIKVA HOUSE.
- Please Notify the Tikva House Staff When Family Members Plan to Arrive or Leave the Tikva House.

Guest #1:

_____

(Title) (First Name) (Middle) (Last)

Date of Birth: _____ Gender: _____ Age: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Cell: _____ Home Phone: _____

Email: _____

- Will you need meals during your stay? □ Yes □ No
- If yes: **Salmon**: □ Yes □ No **Tuna**: □ Yes □ No **Chicken**: □ White Meat □ Dark Meat □ Either
- Food Allergies/Preferences (Chassidishe schita, dairy, pareve, Chalov Yisroel, Pas Yisroel, food likes/dislikes):

_____

Guest #2:

_____

(Title) (First Name) (Middle) (Last)

Date of Birth: _____ Gender: _____ Age: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Cell: _____ Home Phone: _____

Email: _____

- Will you need meals during your stay? □ Yes □ No
- If yes: **Salmon**: □ Yes □ No **Tuna**: □ Yes □ No **Chicken**: □ White Meat □ Dark Meat □ Either
- Food Allergies/Preferences (Chassidishe schita, dairy, pareve, Chalov Yisroel, Pas Yisroel, food likes/dislikes):

_____

Guest #3:

_____

(Title) (First Name) (Middle) (Last)

Date of Birth: _____ Gender: _____ Age: _____

Home Address: _____

City:_____ State: _____ Zip Code: _____

Cell: _____ Home Phone: _____

Email: _____

- Will you need meals during your stay? □ Yes □ No
- If yes: **Salmon**: □ Yes □ No **Tuna**: □ Yes □ No **Chicken**: □ White Meat □ Dark Meat □ Either
- Food Allergies/Preferences (Chassidishe schita, dairy, pareve, Chalov Yisroel, Pas Yisroel, food likes/dislikes):

_____

References:

Reference (name & phone number): _____

Reference (name & phone number): _____

Synagogue (if applicable): _____

Rabbi's Name (if applicable): _____

Rabbi's phone number & email address: _____

Registration:

To reserve a room, there must be a credit card on file. Significant damage to the room will be charged to the credit card on file. Upon check out, a room inspection will be performed.

Credit Card Number: _____

Expiration Date (month/year): _____

Full Name on Card:_____

Billing Street Address/City/State/Zip Code:_____

Authorized Signature: _____ Date: _____

Nightly Rate:

Although there is no fee to stay at the Tikva House, we hope you will consider a donation to help with the upkeep of the Tikva House. ***Some examples of how you can make a difference:***

- □ **A Donation of $100/night (per room/per night) helps covers the cost of cleaning/laundry.**
- □ **A Donation of $250 helps cover the cost of weekday meals.**
- □ **A Donation of $500 helps cover the cost of Shabbos meals.**
- □ **A Donation of $1,000 helps cover the cost of the utilities for a month.**

All Donations Are Tax Deductible. Thank You in Advance for Your Support!

□ **My Rabbi/Synagogue/Organization/Family/Friend** would like to sponsor the cost our stay:

Contact info: _____

□ My medical insurance will cover the cost of our stay. Please call me for information.

□ Check: Please make check/donation payable to: **Jewish Caring Network – Tikva House**

□ Please call me to authorize my credit card donation.

By signing the reservation form, I acknowledge that I have received, read and understand the Guest Rules and are aware that my family, visitors, and myself must abide by these policies in order to remain a guest of the Tikva House. I further agree that Jewish Caring Network – Gevuras Yarden, Inc. (JCN) or their agents, officers, employees, and or volunteers will not be responsible for accident or injury to me and or guests staying with me, or for loss of any personal property and/or personal vehicles. To provide you with appropriate accommodations, resources, and assistance, the staff of the Jewish Caring Network - Tikva House may communicate with your Johns Hopkins medical care team and/or any agency it deems necessary. I understand that this is a cooperative effort by agencies involved to share information that will lead to better utilization of community resources and better cooperation amongst our agencies/organizations to best meet my needs. Any violation of the Tikva House Guest Rules may result in the guest(s) being required to immediately vacate the Tikva House. Guests in violation of these policies may not be eligible to return to the Tikva House for future stays. I acknowledge that the patient and caregivers must meet all eligibility requirements to stay at the Tikva House. I grant permission for the Jewish Caring Network to use photographic image(s) of my family/guests in Jewish Caring Network's promotional materials. I understand that this authorization may be withdrawn by me at any time, in writing, except to the extent that action has already been taken in reliance upon it.

_____	_____	_____
Guest Name - Please Print	Guest Signature	Date Signed

HELP US HELP OTHERS - KINDLY LET US KNOW WHEN YOU HAVE VACATED YOUR ROOM(S).

This way, we will be able to have the room cleaned & ready for the next guest who needs the Tikva House.

TIKVA HOUSE | 529 N. Washington St. | Baltimore, MD 21205
Reservations@TikvaHouse.org | www.TikvaHouse.org | 410-534-1033