Beacon House Lodging Ancillary Request

Please print clearly. Fax completed request to: (617) 643-5875, or email scanned copies to: slscott@partners.org

Today's Date: _____

Requested check in: _____ Check out: _____

Social Worker: _____ Phone Number _____

Patient/Guest Information			
Patient Name:	Is guest patient?	MRN:	# of guest
Guest Name: (if different)	Contact Phone Number:		
Street Address	City	State	Zip

Diagnosis/Service	
Transplant? ☐ Yes ☐ No (if yes, contact Beacon House)	Oncology? ☐ Yes ☐ No
Burn? ☐ Yes ☐ No	Other:

Income Status		
☐ Employed	☐ Unemployed	☐ Other (Please describe)

Occupation	Annual Income	# of dependents

Does insurance cover lodging? ☐ Yes ☐ No	Has other lodging resource been explored?
Has guest been ancillaried before?	If yes, how many times in the past 12 months?
Amount guest will pay: $ _____ per night	Guest should contact Beacon House with credit card information

Briefly describe other financial conditions/situations that may help determine need: _____

_____

By signing you acknowledge that the information provided is up to date and accurate. Discount applies to current stay only.

_____ _____

Lodging Guest Date

_____ _____

Social Worker Date