

8-Week Support Group Application

Name _____ Date _____

Address _____

Phone Number: Home _____ Work _____ Other _____

Email: _____ Is it OK to contact you by email Yes ___ No ___

Birth Date _____ Age _____ Faith Community _____ Occupation _____

Information about the Deceased

Name of Deceased _____ Relationship to Deceased _____

Date of Death _____ Age at Death _____ Place of Death _____

Cause of Death _____

If the deceased was spouse or partner, please complete the following:

Number of years together _____ Anniversary Date _____

Was the person who died a hospice patient? Yes No

If yes, please give the name of the hospice _____

Personal Information/Life Situation

Marital Status: Married Divorced Single Widowed Other _____

Who lives at home with you now? _____

Are there any children living at home? Yes No

If yes: Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Are you currently working? Yes No What kind of work? _____

(Please continue on other side)



Are you currently receiving counseling care? Yes No

Therapist Name _____ Phone _____

Have you been diagnosed as having a mental health diagnosis? Yes_____ No____

If yes, please identify: _____

Have you seriously considered or attempted suicide? Yes_____ No____

If yes, please explain: _____

Are you currently receiving medical care? What kind? _____

If yes, what is your Physician's name? _____ Phone _____

Are you taking any medications regularly? Yes___ No____

If yes, please list: _____

Have you ever abused drugs or alcohol? Yes_____ No_____ Explain _____

Where did you hear about our Bereavement Services?

Hospice _____ Friend _____
Church/Synagogue _____ Work _____
Therapist _____ Other _____

I would prefer a group in the:

Winter _____ Spring _____ Summer _____ Fall _____

I can attend a group in the:

Morning _____ Afternoon _____ Evening _____

Please send completed application to:

Grief Services
HospiceCare of Boulder & Broomfield Counties
1585 Patton Drive
Boulder, CO 80303

Please submit this application in order to register for the next group. Group facilitators will contact you to schedule an individual pre-group meeting in the month prior to the group start date. If you have any questions, please call **303.604.5300**.

***Information included on this form is protected by the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and will remain confidential between the applicant and Hospice Care group facilitators and will not be shared with the group without specific permission.*