STORY APPLICATION & INTAKE FORM

Free mini-documentary films for families facing illness · info@beyondthevision.org · Peachtree City, Georgia

OFFICE USE — APPLICATION ID	DATE RECEIVED	RECEIVED BY	SOURCE (WEBSITE / REFERRAL / EVENT)

This is the full application. If you started online, we complete this together at your consultation. Every film is professionally shot and edited, shaped by the family, and delivered free of charge. Complete every section that applies and print clearly in ink.

HOW WE PROTECT EVERY FAMILY

Because our films are free and demand is high, we verify every application. We contact your healthcare provider through the facility's published main number, we call two references, and we confirm photo ID in person at your consultation. **We never ask for payment, banking details, Social Security numbers or gift cards. If anyone claiming to represent us asks you for money, it is not us.** Knowingly providing false information ends the application.

SECTION 1 · WHO IS SUBMITTING THIS FORM

☐ I am the participant ☐ I am applying for someone I love ☐ I am honoring someone who has passed

☐ I am a healthcare provider, hospice coordinator, social worker, chaplain or case manager referring a participant

YOUR FULL LEGAL NAME _____ RELATIONSHIP TO THE PARTICIPANT _____ DATE OF THIS APPLICATION _____

DAYTIME PHONE _____ EMAIL ADDRESS _____ BEST DAYS / TIMES TO REACH YOU _____

YOUR MAILING ADDRESS (STREET, CITY, STATE, ZIP) _____ HOW LONG AT THIS ADDRESS _____

SECTION 2 · PARTICIPANT INFORMATION

PARTICIPANT FULL LEGAL NAME _____ PREFERRED NAME _____ DATE OF BIRTH _____

PARTICIPANT MAILING ADDRESS (STREET, CITY, STATE, ZIP) _____ COUNTY _____

PARTICIPANT PHONE _____ PARTICIPANT EMAIL _____ PRIMARY LANGUAGE _____ AGE _____

Can the participant take part in a filmed interview?

☐ Yes, fully ☐ Yes, with limits (below) ☐ No — family will tell the story ☐ Participant has passed

IF LIMITED, PLEASE DESCRIBE (ENERGY LEVEL, SPEECH, MOBILITY, TIMING)

_____

PARTICIPANT NAME: _____

SECTION 3 · WHICH PROGRAM ARE YOU APPLYING FOR

Choose one. We will confirm the right fit at your consultation.

☐ **Legacy Storytelling**	10–15 min	A life told in the participant's own words, for the family to keep.
☐ **Memorial Legacy**	10–15 min	For families who have said goodbye, told through memories, photos and home video.
☐ **Youth Legacy**	5–10 min	Room for a young person to share their dreams, courage and voice.
☐ **Caregiver Storytelling**	5–10 min	Honoring the person who shows up every single day.
☐ **Fundraising Advocacy**	2–3 min + 3 socials	A short feature that helps a community rally around a family.

How soon is this needed?

☐ Within 30 days ☐ 30 to 90 days ☐ Flexible ☐ Unsure

Would the family like the optional one-minute shareable short for social media?

☐ Yes ☐ No ☐ Decide later

IF URGENT, PLEASE EXPLAIN THE TIMING

HAS ANY OTHER ORGANIZATION FILMED THIS STORY?

SECTION 4 · ELIGIBILITY — REQUIRED

Which describes the participant's situation?

☐ Chronic illness ☐ Terminal illness ☐ Life-changing injury

☐ Caregiver for someone living with illness or injury ☐ Participant has passed (Memorial Legacy)

GENERAL DESCRIPTION OF THE DIAGNOSIS, CONDITION OR INJURY (NO MEDICAL RECORDS NEEDED)

APPROXIMATE DATE OF DIAGNOSIS OR INJURY

Current care setting

☐ Home ☐ Hospital ☐ Hospice ☐ Rehabilitation ☐ Long-term care ☐ Other

NAME OF HOSPITAL, HOSPICE, OR FACILITY

CITY AND STATE OF FACILITY

PARTICIPANT NAME: _____

SECTION 5 · VERIFICATION CONTACT — REQUIRED

WE CONTACT THIS PERSON DIRECTLY

An application cannot be approved without someone who confirms eligibility. We reach them through the organization's publicly listed main number rather than a number supplied only on this form, and we ask one question: whether the participant meets our eligibility criteria. **We do not request or accept medical records.** A work email at the organization's own domain is required; personal email accounts cannot be used for verification.

For **Memorial Legacy**, this may instead be the hospice, funeral home, clergy member or attending provider who can confirm the circumstances.

VERIFICATION CONTACT FULL NAME _____ CREDENTIALS / TITLE _____ YEARS KNOWN TO THE PARTICIPANT _____

Their role

☐ Physician ☐ Nurse or NP ☐ Hospice coord. ☐ Social worker ☐ Chaplain ☐ Case manager ☐ Funeral home

ORGANIZATION OR PRACTICE NAME _____ MAIN PHONE (PUBLISHED NUMBER) _____

DIRECT PHONE OR EXTENSION _____ WORK EMAIL (MUST USE THE ORGANIZATION'S DOMAIN) _____

☐ **I authorize Beyond the Vision to contact the person named above to confirm eligibility for this program.** APPLICANT INITIALS _____

SECTION 6 · TWO REFERENCES — REQUIRED

References must be adults who are **not related to the participant** and have known the participant or family at least one year. We call both.

REFERENCE 1 — FULL NAME _____ RELATIONSHIP _____ YEARS KNOWN _____ PHONE _____

REFERENCE 1 — EMAIL _____ BEST TIME TO CALL _____

REFERENCE 2 — FULL NAME _____ RELATIONSHIP _____ YEARS KNOWN _____ PHONE _____

REFERENCE 2 — EMAIL _____ BEST TIME TO CALL _____

SECTION 7 · IDENTITY VERIFICATION — REQUIRED

Bring the following to your consultation. We view originals in person, record only that verification took place, and **do not keep copies or ID numbers**.

- ☐ Government-issued photo ID for the participant
- ☐ Government-issued photo ID for the person submitting this form, if different
- ☐ Proof of the address listed above (utility bill, lease, or dated mail from the last 60 days)
- ☐ If signing on the participant's behalf: documentation of legal authority (power of attorney, guardianship, or healthcare proxy)
- ☐ For Memorial Legacy: an obituary, funeral program, or death certificate

PARTICIPANT NAME: _____

SECTION 8 · FUNDRAISING ADVOCACY ONLY — SKIP IF NOT REQUESTED

Complete this section only if you chose **Fundraising Advocacy** in Section 3.

What will the funds be used for?

- ☐ Medical bills
- ☐ Treatment travel and lodging
- ☐ Household and living expenses
- ☐ Caregiving costs
- ☐ Funeral or final expenses
- ☐ Other (describe below)

FUNDRAISING GOAL AMOUNT ($) _____

IF OTHER, DESCRIBE THE NEED _____

Is a fundraising campaign already active?

- ☐ No, not yet
- ☐ Yes — list the platform and full link below

PLATFORM (GOFUNDME, GIVESENDGO, CHURCH FUND, OTHER) _____

CAMPAIGN LINK _____

Who legally receives the donated funds?

- ☐ The participant
- ☐ A family member
- ☐ A trust or fiduciary
- ☐ A church or nonprofit

FULL LEGAL NAME OF THE PERSON OR ENTITY RECEIVING FUNDS _____

RELATIONSHIP TO THE PARTICIPANT _____

COURT-APPOINTED GUARDIAN, CONSERVATOR, OR POWER OF ATTORNEY? IF YES, NAME THEM _____

OTHER ORGANIZATIONS CURRENTLY ASSISTING _____

☐ **I understand that Beyond the Vision makes the films only. We never collect, hold, receive, or distribute donated funds, and we are not responsible for how funds raised are used.**

INITIALS _____

SECTION 9 · ABOUT THE STORY

In your own words. There are no wrong answers, and we will shape the rest together at your consultation.

In a few sentences, who is this film for and what story matters most?

Places that matter to the participant, and people who should appear in the film

Anything we should know or avoid — topics, sensitivities, mobility or scheduling needs

PARTICIPANT NAME: _____

SECTION 10 · CONSENT, RELEASE AND ATTESTATION — REQUIRED

- ☐ I certify that every statement in this application is true and complete to the best of my knowledge.
- ☐ I authorize Beyond the Vision to verify all information provided, including contacting the verification contact and both references named above.
- ☐ I understand that knowingly providing false information ends this application immediately.
- ☐ I consent to being filmed, photographed and recorded, and I understand I may pause or withdraw at any time before the film is delivered.
- ☐ I understand these services are provided at no cost, and that no one representing Beyond the Vision is authorized to request payment, banking information, or gift cards from me at any time.
- ☐ I understand films stay private by default. My family decides who sees the film, and public use of any footage requires a separate written release that I may decline without affecting my film.
- ☐ I grant Beyond the Vision permission to keep a copy of the finished film in its archive.
- ☐ I have read and understand how my information will be used and stored.

PARTICIPANT SIGNATURE	PRINTED NAME	DATE

If signed by someone other than the participant, complete the following:

REPRESENTATIVE SIGNATURE	PRINTED NAME	DATE

Legal authority to sign

☐ Power of attorney ☐ Legal guardian ☐ Healthcare proxy ☐ Next of kin ☐ Parent ☐ Executor

WITNESS PRINTED NAME (RECOMMENDED)	WITNESS SIGNATURE	DATE

PARTICIPANT NAME: _____

SECTION ★ · FOR OFFICE USE ONLY — VERIFICATION CHECKLIST

Do not send this page to the applicant. Approval requires two staff signatures.

VERIFICATION STEP	DONE	DATE	INITIALS
Application complete; every required section filled	☐		
Program selection confirmed and appropriate	☐		
Organization main number independently confirmed (public listing, not this form)	☐		
Verification contact reached on that confirmed line and identity confirmed	☐		
Verification contact confirmed eligibility	☐		
Work email verified as organization domain	☐		
Reference 1 contacted and consistent with application	☐		
Reference 2 contacted and consistent with application	☐		
Participant photo ID verified in person	☐		
Submitter photo ID verified in person (if different)	☐		
Proof of address verified	☐		
Legal authority documentation reviewed (if representative signed)	☐		
Memorial Legacy: obituary, funeral program or death certificate reviewed	☐		
Fundraising Advocacy: campaign link reviewed and fund recipient confirmed	☐		
Duplicate or prior application check completed	☐		
Consultation scheduled	☐		

RED FLAGS OR NOTES

Decision

☐ Approved ☐ Declined ☐ More information needed ☐ Referred to another organization

REVIEWER 1 NAME AND SIGNATURE _____

REVIEWER 2 NAME AND SIGNATURE _____

DATE _____