REQUEST A POPS MENTOR

Parents Offering Parent Support (POPS)

_____ _____ _____
Your Name Phone (Home) Phone (Cell)

_____
Home Address

_____
E-mail

_____ _____ _____
Name of child with health needs/experience Child's Date of Birth Relation to you

_____
Child's Primary Diagnosis

To help us find the best match, please share any additional information _____

_____

Do you have other children? If yes, please list names and dates of birth ☐ Yes ☐ No

_____ _____ _____

Preferred way to contact (phone / email; time of day)

_____

Please indicate your preference for a trained volunteer mentor to match:

☐ Has a child with a same or similar diagnosis ☐ Other _____
☐ Has a child about the same age as my child

_____

RELEASE OF INFORMATION: I give my permission for Parents Offering Parent Support (POPS) to release my name, telephone number and the information I have volunteered on this form to another parent which a Family Centered Care Coordinator has screened and trained for a parent match.

I also understand that failure to participate in this program will not affect my child's ongoing care or treatment at Children's Mercy. I may end participation in this program at any time by contacting a Family Centered Care Coordinator.

Signature _____ **Date**_____

Relation to this child_____

Please return this form to: Family Centered Care Coordinators, Children's Mercy, 2401 Gillham Road, Kansas City, MO 64108
Email: www.pops@cmh.edu Questions: (816) 302-8229