The application process to request temporary housing at Ronald McDonald House Charities of Mobile includes completion of a background check through SELECTION.COM. **All individuals 19 years of age and older are required to complete the online application with SELECTION.COM.**
Below is the referral process:

- Nurse, Doctor, Social Worker or representative from a referring agency should completely fill out the referral and email to info@rmhcmobile.org or fax to 251-438-2222.
- Once RMHC receives the referral, each individual listed 19 years of age or older will receive an email to complete a background check.
  - **If an individual doesn't have an email address, please encourage them to get a free email such as gmail. If that is not possible, have them fill out the hard copy and fax it with the referral.**
  - **If an individual has email, but no internet, they may use the computer located inside the Ronald McDonald Family Room located on the 4th floor of the new Children's Tower.**
- Results are received very quickly and the manager on duty will contact the family as soon as they are received.

Crimes Against Children – including without time limitation, and crime involving a child, including physical abuse, neglect, emotional maltreatment, and sexual abuse

Sexual Predator Crime or Registered Sex Offender – including without time limitation, rape, molestation, sexual abuse/battery, voyeurism, stalking, or public indecency

Domestic Violence – without time limitation

Murder – including without time limitation homicide and manslaughter

Kidnapping – including without time limitation, abduction, false imprisonment, capture or seize

Arson – including without time limitation, pyromania, incendiarism or torching

Felony Assault/Battery – without time limitation

Felony Theft – including without time limitation, robbery, larceny, carjacking, burglary, receiving stolen property, grand theft, breaking and entering

Terrorism - without time limitation

Weapons – including within the last 5 years possession, discharging or selling

Fraud/Embezzlement – within the last 5 years

Vandalism – within the last 5 years

Resisting Arrest – within the last 5 years

Multiple Misdemeanor Drug Convictions (more than 1) - within the past 5 years

Felony Drug Convictions – including within the last 5 years, possession, trafficking, distribution, selling or manufacturing

Misdemeanor Assault/Battery – within the last 5 years

Or existing or former offense of any municipal corporation, this state or any other state, or the United States that is substantially equivalent to any one of these offences.

Thank you,

RMHC of Mobile, Manager

Please remember that a free copy of your background check may be obtained through SELECTION.COM Should you have any dispute with the results, contact SELECTION.COM (155 Tri-County Parkway, Suite 150, Cincinnati, OH 45246 or 800-325-3609) directly for clarification.

REFERRAL FOR ACCOMMODATIONS

THIS IS A REQUEST ONLY
Guaranteed reservations are not available.

Ronald McDonald House Charities®
Mobile

Guest rooms are assigned on a first-come, first-served basis and a waiting list will be used during periods of high demand. The referring family must have a child 21 years of age or younger in one of our area hospitals and live at least 20-25 miles away. **Please complete the referral form and email it to info@rmhcmobile.org or FAX it to 251-438-2222**. For questions, call the on-duty manager at RMHC 251-694-6873.

Today's Date: ______________ Estimated Length of Stay: ______________ Arrival Date: ______________

Name of Social Worker
or Person Referring: ______________ Phone: ______________ Pager: ______________

Hospital: ______________ ☐ New ☐ Returning

Primary Caregivers

Name: ______________ Relation: ______________ Name: ______________ Relation: ______________

Email (Required): ______________ Email (Required): ______________

Are Parents Over 18: ☐ Yes ☐ No

Home Street Address (No P.O. Boxes): ______________

City: ______________ State: ______________ Zip: ______________ County: ______________

Phone 1: ______________ Phone 2: ______________

Patient Name: ______________ ☐ Male ☐ Female

☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Multi-Racial ☐ Other: ______________

Patient DOB: ______________ Hospital Room #: ______________ Unit/Floor: ______________

General Diagnosis or Procedure, if known: ______________

☐ 1 Accident ☐ 2 Cardiology ☐ 3 Premature ☐ 4 Outpatient Procedure
☐ 5 Cancer ☐ 6 Neurology ☐ 7 Respiratory ☐ 8 Surgery ☐ 9 Burn ☐ 10 Other

Name, Relation, and Email of other guests (email required):

Name: ______________ Relation: ______________
Email (Required): ______________

Name: ______________ Relation: ______________
Email (Required): ______________

Name: ______________ Relation: ______________
Email (Required): ______________

Name: ______________ Relation: ______________
Email (Required): ______________

Name(s) and ages of children under 18 years of age (other than patient):

____
____
____
____
____
____

COVID-19 SCREENING

Please answer the following questions in an effort to keep our RMHC-Mobile guest families safe and healthy. **If any answer is "Yes," please speak with a staff member.**

- Are you experiencing any kind of illness, even light symptoms including (but not limited to) fever, cough or shortness of breath in the past 14 days? ☐ Yes ☐ No
- Have you traveled to, or been exposed to anyone outside the area or region in the past 14 days: ☐ Yes ☐ No
- Have you been exposed to anyone with COVID-19 or been around anyone with symptoms of fever, cough or shortness of breath in the last 14 days? ☐ Yes ☐ No
- Have you presented an elevated temperature when checking in at the hospital in the last 24 hours? ☐ Yes ☐ No
- Does patient and/or family member have any known communicable diseases? ☐ Yes ☐ No
  If yes, have medical staff complete medical clearance form below.

If you have traveled at all in the past 14 days please consider visiting RMHC Mobile at a later date.

Name (print): ______________________________

Signature: ______________________________

Date: ______________________________

Family-centered residential facility
MEDICAL CLEARANCE FORM

This form must be completed by the medical staff who is currently involved in the child's medical care.

Primary Caregiver/Family Members

Name (print): ______________________________

Name (print): ______________________________

Name (print): ______________________________

Name (print): ______________________________

Pediatric Patient's Name (print): ______________________________

Pediatric Patient's Diagnosis (please circle):

☐ Chickenpox (Varicella)	☐ Mumps	☐ Salmonella Colitis/Diarrhea
☐ Measles	☐ Whooping Cough (pertussis)	☐ Shigella Colitis/Diarrhea
☐ Tuberculosis	☐ Hepatitis A	☐ Other: ______________
☐ E Coli Colitis/Diarrhea/HUS	☐ Herpes infection (HSV-1 or HSV-2)	

I have reviewed the above named patient's records and determined the exposed family members NOT contagious to other residential facility guests. Please mark as appropriate below.

- ☐ Family Members have history of complete immunization or natural disease immunity against this specific disease.
- ☐ Family members have completed a full course of appropriate antibiotic exposure prophylaxis against this specific disease.
- ☐ Family members have been evaluated and cleared by public health department.
- ☐ Family members are currently not ill, and not considered a risk since currently healthy.
- ☐ Patient and/or family members have no known communicable diseases.

Physician/public health official (print name): ______________________ Date of Evaluation: ______________

Physician/public health official (signature): ______________________________

Physician/public health official contact phone: ______________________________