



Bee Mighty provides support and resources to families before, during and after their journey in the Neonatal Intensive Care Unit.

Counseling Program Application

PERSONAL INFORMATION

Child's Name (First, Middle, Last) _____

Male/ Female _____

Address: _____

Child's DOB ___/___/_____

Parent/Guardian(s) Name(s): _____

Address (if different from child): _____

Phone: _____

Email(s): _____

MEDICAL INFORMATION

Where was your child in the NICU (Hospital Name/ City/ State)?

Length of NICU Stay: _____

Diagnosis: _____

APPLICATION REQUIREMENTS

Family Size _____ Household Income _____

What kind of counseling are you interested in today? (Check all that apply)

Individual

Couples

Family

Name(s) of person(s) requesting counseling? _____

Have you ever received counseling in the past? _____

Please describe the reasons you are seeking counseling today.

Have you previously been awarded a grant from Bee Mighty or Pierce's Project?

Yes ___ No ___ If yes, when and what type? _____

How did you hear about us? _____

Would you be willing to share your NICU story? Yes ___ No ___

Would you be interested in getting involved with Bee Mighty?

Yes ___ Not at this time ___

CONFIDENTIAL

Information shared on this application remains confidential and will only be used to the extent necessary for receiving counseling services.

Email is the preferred way of submitting applications & documents

Email: beemightyapplications@gmail.com

Phone: (980)272-1596