2025-2026
Family Application

Ronald McDonald Family Retreat
at Krantz Cottage

Patient Information

First Name ______________________ Last Name ______________________

Date of Birth ____ / ____ / ____ Age ________ Sex ☐ M ☐ F

Street Address ____

City __________________ State _______ Zip ____________ County ______________

Diagnosis ______________________ Treatment Facility ________________

Doctor's Name ____________________ Doctor's Phone ______________________

Has the patient's family used a Ronald McDonald House or Family Room? ☐ Y ☐ N

If yes, where? ____

How did you hear about the Ronald McDonald Family Retreat? ________________

Were you referred by RMHC staff or a medical professional? ☐ Y ☐ N

If yes, who? ____

Parent/Guardian Information

Relationship to Patient ____________________

First Name ______________________ Last Name ______________________

Date of Birth ____ / ____ / ____ Age ________ Sex ☐ M ☐ F

Cell Phone __________________ Email ______________________________

Relationship to Patient ____________________

First Name ______________________ Last Name ______________________

Date of Birth ____ / ____ / ____ Age ________ Sex ☐ M ☐ F

Cell Phone __________________ Email ______________________________

Additional Retreat Guests

First Name __________________ Last Name __________________ Sex ☐ M ☐ F

Date of Birth ____ / ____ / ____ Age ____ Relationship to Patient ____________

First Name __________________ Last Name __________________ Sex ☐ M ☐ F

Date of Birth ____ / ____ / ____ Age ____ Relationship to Patient ____________

First Name __________________ Last Name __________________ Sex ☐ M ☐ F

Date of Birth ____ / ____ / ____ Age ____ Relationship to Patient ____________

First Name __________________ Last Name __________________ Sex ☐ M ☐ F

Date of Birth ____ / ____ / ____ Age ____ Relationship to Patient ____________

Total # Adults ________ Total # Children _______

(Please include patient, parent/guardian(s), and all additional guests)

Visit Information

- Check-in is available Wednesday between 9:00 a.m. and 5:00 p.m.
- Checkout is Sunday by 9:00 p.m.

Please indicate preferred time to stay at the Ronald McDonald Family Retreat

- ☐ Spring (April/May/June)
- ☐ Summer (July/August)
- ☐ Fall (September/October/November)
- ☐ Winter (December-March)
- ☐ We are open to dates available

Please explain the intended purpose of your stay at the Family Retreat.

Does anyone in your family have any accessibility needs? ☐ Y ☐ N

(Please specify, including need for adaptive technology, if applicable)

Does anyone in your family have any special requirements? ☐ Y ☐ N

(Please specify and include specific dietary restrictions, if applicable)

Please return completed application by mail or email to:

Family Retreat Intake Committee
intake@rmhcofalbany.org
RMHC of the Capital Region
139 South Lake Ave, Albany, NY 12208

RMHC of the Capital Region (RMHC-CR) provides essential services that remove barriers, strengthen families, and promote healing when children need healthcare. The Ronald McDonald Family Retreat at Krantz Cottage provides a peaceful, supportive setting where families experiencing serious childhood illness can enjoy being together, making lasting memories. All RMHC-CR programs and services are provided at no cost to families. It is the policy of RMHC-CR to treat all stakeholders, including all guest families and program beneficiaries, fairly and with compassion, without regard to income or ability to pay, race, color, ethnic origin, national origin, religion, political affiliation, age, gender, sexual orientation, gender identification, disability or handicap, housing status, marital status, veteran status or any other group, status or characteristic protected by locally applicable laws and regulations.