



Helping Hands Assistance Program

Dear Applicant:

The Spencer Hospice Foundation is a community non-profit organization dedicated to enhancing the lives of terminally ill patients and their families.

In supporting our mission, the Helping Hands Assistance Program aids hospice patients by fulfilling simple quality of life requests. *Examples of such requests may include providing a portable heater or air conditioning unit, supplying a bag of groceries or helping to cover the cost of a co-payment.*

Helping Hands Criteria:

- Patient must have a life expectancy of one year or less
- Patient and family must demonstrate financial need
- Please enclose a photograph of the patient with the application if possible.

All applications must be submitted by mail or delivered to:

Spencer Hospice Foundation
Helping Hands Assistance Program
3401 W. Sunflower Ave. Ste. 225
Santa Ana, CA 92704

We will make our best efforts to assist with all eligible applicants as quickly and effectively as possible.

Warm Regards,

The Spencer Hospice Foundation

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Please read this form very carefully and follow all the instructions to ensure the proper completion of the application **FRONT & BACK**

Helping Hands Application

GENERAL INFORMATION

Date: _____

HOSPICE ORGANIZATION INFORMATION (To be Completed by Hospice Representative)

Hospice Representative Name: _____

Title: _____ E-mail: _____

Organization Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____
Last First M.I

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Age: _____ Annual Family Income: \$ _____

Terminal Diagnoses: _____ Life Expectancy: _____

CAREGIVER INFORMATION

Name of Primary Caregiver/Contact Person: _____

Relationship to Patient: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

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REQUESTED NEED

Please describe the specific need of the patient and the cost involved:

Please describe the purpose of the request:

Approved for Submission by the Patient or Primary Caregiver:

Patient/ Primary Caregiver/DPOA Name: _____

Signature: _____

Approved for Submission by IDT Representative:

Name: _____ Position: _____

Signature: _____



PUBLICITY RELEASE

If your request is approved, the Spencer Hospice Foundation would like your permission to use your information and/or photo in one or all of the media outlets listed below. When you choose to accept all of the options, it helps the Spencer Hospice Foundation to raise awareness and donations for your need, as well as the needs of others. The Spencer Hospice Foundation respects the privacy of individuals and will only use the patient’s first name when publishing their story and/or photograph.

Please check the box next to all media that is acceptable:

- Local Newspaper, Radio, TV
- State and National Newspaper, Radio, TV
- Spencer Hospice Foundation Newsletter
- Spencer Hospice Foundation Web Site
- Spencer Hospice Foundation Direct Mail
- All of the Above

None of the Above. Please do not use my story/and or photo in any of the media

Patient/ Primary Caregiver/DPOA Name

Signature

Date



HIPAA FORM

Authorization for Use/Disclosure of Protected Health Information

RE: _____
(Patient - Print Name Legibly)

I authorize the use and disclosure to the Spencer Hospice Foundation of protected health information about Patient as described below: Information that may be used/disclosed: All protected health information relating to Physician’s assessments of:

- (a) whether Patient is medically eligible for Spencer Hospice Foundation services; and
- (b) if so, whether his/her request is medically appropriate.

In addition, Physician is authorized to fill out, sign and provide to the Spencer Hospice Foundation forms that the Spencer Hospice Foundation may require, including forms relating to Patient’s medical eligibility, the requested need and medical considerations relating thereto. Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives. Persons authorized to receive the information: Employees or other authorized representatives of:

THE SPENCER HOSPICE FOUNDATION
3401 W. SUNFLOWER AVE. SUITE, 225 TEL: 888-469-1581
SANTA ANA, CA 92704 FAX: 714-597-8275

Purpose for which information will be used/disclosed: To enable the Spencer Hospice Foundation to obtain:

- (a) Physician’s assessments regarding whether Patient is medically eligible to have a request granted by the Spencer Hospice Foundation and, if so, whether the request is medically appropriate;
- (b) Pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient’s request has been granted by the Spencer Hospice Foundation or a final determination has been made that Patient is not eligible to receive the requested need. Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following

- (a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization
- (b.) I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient/ Primary Caregiver/DPOA Name	Signature	Date
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Please Read, Sign and Return with Your Application

Patient: _____

Request: _____

- 1. Granting of the Special Need.** The Spencer Hospice Foundation (SHF) agrees to pursue the fulfillment of the special need of the person named above (“Patient”) in accordance with the terms and conditions of this Agreement. SHF reserves the right in its sole discretion, to decide if a special need will be granted.
- 2. Waiver.** The patient hereby waives any and all rights he or she may have or may hereafter acquire against SHF, its officers, directors, agents, and employees arising out of any injury, damages, or losses suffered by the patient, family, friends, or any of them, arising out of or in any way related to SHF preparation, execution or fulfillment of the special need, regardless of whether such loss or harm is caused by the active, passive or gross negligence of SHF or any other person.
- 3. Release.** Patient, relatives or friends, together, and each of them individually, does hereby forever release and remise SHF, its officers, directors, agents, and employees from any and all claims, lawsuits, damages, or losses arising out of or in any way related to SHF, execution or fulfillment of the request. And suffered by patient, relatives or friends, or any of them of whatever nature, and of whatever extent, regardless of whether such loss or damage is caused by the active, passive or gross negligence of SHF or any other person.
- 4. Indemnity.** Patient, relatives or friends, together and each of them individually, hereby agree to indemnify and hold harmless SHF, its officers, directors, agents, and employees of and from any and all losses suffered by SHF, its officers, directors, agents, and employees as the result of any claim, lawsuit, or action arising out of or relating in any manner to SHF’s preparation, execution and fulfillment of the special need. Indemnity includes, but is not limited to, reasonable attorneys fees and costs incurred by SHF, its officers, directors, agents, and employees in retaining attorneys of SHF choice to defend any and all such claims, lawsuits, and actions.
- 5. Request Expenses.** The expenses SHF has agreed to pay for are those foreseeable and directly related to the fulfillment of the special need. Patient, relatives or friends, together understand that they may be forced to incur substantial expenses as a result of unforeseen events or circumstances beyond SHF’s control, especially if fulfillment of the request involves travel. SHF shall not have any responsibility or liability for expenses incurred by patient, relatives or friends which have not been expressly assumed by SHF pursuant to this Agreement, which have been caused by unforeseen events, or circumstances beyond SHF control.
- 6. Representations and Warranties.** Patient, relatives or friends together and each of them individually, make the following representation and warranties to SHF:
 - (a) they have made a true and full disclosure of medical condition to SHF;
 - (b) they will notify SHF if and when patient’s medical condition should deteriorate at any time prior to fulfillment of the special need.
 - (c) if fulfillment of the special need involves travel, they are able to bear the financial burden of the substantial expenses which they may be forced to personally incur as a result of unforeseen circumstances or events beyond SHF’s reasonable control, or that they assume the risk and personal responsibility for such expenses;
- 7. Termination of Request.** The Spencer Hospice Foundation reserves the right, in its sole and absolute discretion, to abort preparation or fulfillment of the special need at any time after the signing of this Agreement, if SHF should determine that:
 - (a) Fulfillment of the special need will endanger the health and safety of patient or of others
 - (b) The patient is or will be incapable of appreciating or utilizing the goods, services, or activities related to the special need
 - (c) Events or circumstances render it impractical, imprudent, or inadvisable to fulfill or continue to fulfill the special need
 - (d) Patient has breached any of the representations and warranties contained in this Agreement.

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In the event SHF aborts preparation, or fulfillment of the special need, patient, relatives and friends agree that SHF shall not be held liable or responsible for any expenses which patient, relatives and friends may have incurred in contemplation of SHF's fulfilling the special need.

8. Further Assurances. Patient, relatives and friends agree that he or she shall, at the request of SHF, execute and deliver to SHF all further documents that the Spencer Hospice Foundation deems necessary or appropriate in order to prepare, execute and fulfill the special need.

9. Counterparts. This Agreement may be executed in counterparts, any of which shall be deemed to be an original.

10. Amendment. This Agreement shall not be modified or superseded, except by a writing executed by the parties.

11. Governing Law. This Agreement shall be governed by the laws of the state in which SHF is based.

12. Binding Effect. This Agreement is binding on all heirs, successors, representatives, and assigns of all parties hereto.

13. Severability. If any portion of this Agreement shall be determined to be invalid or unenforceable, all other portions shall remain valid and enforceable.

14. Entire Agreement. This Agreement constitutes the entire Agreement and understanding of the parties with respect to the transaction contemplated hereby, and supersedes all prior agreements, arrangements and understandings related to the subject matter. No representation, promise, inducement or statement of intention has been made by any of the parties hereto not embodied in this Agreement, and no party shall be bound by or liable for any alleged representation, promise, inducement or statements of intention not set forth or referred to herein.

15. Captions. The Captions appearing in this Agreement are for convenience and ease of reference only. They in no way describe, limit or extend this Agreement or any of its provisions.

16. Proof of Financial Hardship. Patient understands SHF reserves the right to request documentation of financial hardship.

17. Grant of Right of Publicity. PARTICIPANTS UNDERSTAND AND AGREE THAT FULFILLMENT OF THE SPECIAL NEED MAY RESULT IN PUBLICITY, WHETHER OR NOT THE SPENCER HOSPICE FOUNDATION ACTIVELY TAKES STEPS TO PUBLICIZE THE REQUEST.

IMPORTANT: By signing below, you affirm and acknowledge that you have read this Agreement, have received a copy and fully understand its provisions.

PATIENT NAME

DATE

DPOA/PRIMARY CAREGIVER

DATE

HOSPICE STAFF REPRESENTATIVE

DATE

SHF STAFF OR BOARD MEMBER

DATE

TURN OVER TO COMPLETE!