Treasured Time
Giving the gift of moments

Gift of Moments Referral Package

Instructions to Referral Agent:
All Gift of Moments referral candidates must meet all the eligibility requirements listed below prior to making a referral. Please submit the referral form by postal mail or via fax.

Eligibility Requirements:
All referral candidates must:

1. have a life threatening illness;

2. have at least one (1) child between the ages of three(3) and eighteen(18). Only one child needs to meet the age requirement;

3. have the ability to obtain medical documentation that supports diagnosis

4. all referrals must not have previously participated in another similar wish program.

Instructions: Please fully complete Sections I – VI. To be eligible, all forms must be fully completed, including all required signatures.

Referral candidates will be contacted after the Gift of Moments referral package, including all forms, has been received.

Please mail or fax the completed referral package to:

Treasured Time, Inc
C/O Cassandra O'Hara
PO Box 152
Seymour, CT 06483
Fax#: 203-283-5418

Should you have any questions, please do not hesitate to contact, Cassandra, at (914) 843-9406.

Thank you for helping Treasured Time, Inc. to provide a Gift of Moments for your referral candidate and his/her family.

Section I
Referral Information Form

Instructions: **Please input information regarding the referral candidate family.**

Referral/Patient Information: (As listed on your driver's License)
Last Name: _____First Name: _____ M.I.:____

Date of Birth: _____SS#: _____

Spouse Last Name: _____ First Name: _____ M.I.:____

Spouse Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____-_____

Work: (____) _____-_____

Cell Phone: (____) _____-_____

Spouse's Cell: (____) _____-_____

Fax: (____) _____-_____

E-mail Address: _____ Spouse E-mail: _____

Names of Children, Dates of Birth, and Gender :

Name:_____ Date of Birth: _____ Gender: M/F

Name:_____ Date of Birth: _____ Gender: M/F

Name:_____ Date of Birth: _____ Gender: M/F

Name:_____ Date of Birth: _____ Gender: M/F

Emergency Contact Information: (a person who will not be attending event)

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____-_____

Work: (____) _____-_____

Cell Phone: (____) _____-_____

E-mail Address: _____

Section II
Demographic and Statistical Information Form

Instructions: Please input requested demographic and statistical information. This section is required to be completed for statistical purposes only. Treasured Time, Inc. would like to track the demographic profiles of all beneficiaries, to help us make the most of the program. Please check one (1) answer or write in an answer, as appropriate.

Ethnicity of Referred Patient:

- ❑ African American
- ❑ Asian
- ❑ Caucasian
- ❑ Hispanic
- ❑ Native American
- ❑ Other

Total Family Income of Referred Patient's Family:

- ❑ Less than (<) $25,000
- ❑ $25,001-$50,000
- ❑ $50,001-$100,000
- ❑ $100,001-$150,000
- ❑ $150,001-$200,000
- ❑ Greater than (>) $200,000

Patient's Occupation: _____

Patient's Employer: _____

Spouse's Occupation: _____

Spouse's Employer: _____

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Section III
Physician Referral Agent Information Form

Instructions: The referring physician staff person ("Referral Agent") should complete this form, to provide Treasured Time, Inc. necessary contact information.

Contact Information: (Person at physician's office that we can contact should we need additional information.)

Last Name: _____ First Name: _____ M.I.: ____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (____) _____-_____

Work: (____) _____-_____

Cell Phone: (____) _____-_____

Fax: (____) _____-_____

E-mail Address: _____

Name of Hospital/Cancer/Oncology Center/Organization:

Address: _____

City: _____ State: _____ Zip code: _____

Phone: (____) _____-_____

Fax: (____) _____-_____

Website: _____

E-mail Address: _____

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Section IV
Medical Information Form

Instructions: This form is to be completed by the referred patient's treating physician. Where appropriate please fill in an answer or mark [X] in the appropriate box.

Physician's Name: _____

Hospital/Center/Organization Affiliation: _____

Patient's Name: _____

Diagnosis: _____

_____

Time Frame of Gift of Moments

- ❑ within 1 – 2 months
- ❑ within 3 – 4 months
- ❑ within 5 – 6 months
- ❑ 6 months – 1 year

Activity Level Permitted

- ❑ Sedentary
- ❑ Moderate
- ❑ No Limitations

Travel Limitations:

Can travel out of home city?	❑ Yes	❑ No
Can travel for several days?	❑ Yes	❑ No
Can travel by car?	❑ Yes	❑ No
Can fly via commercial airlines?	❑ Yes	❑ No
Can fly via private airplane?	❑ Yes	❑ No
Requires ADA room?	❑ Yes	❑ No
Limit exposure to light?	❑ Yes	❑ No

Please specify maximum duration of travel: _____

Please explain any limitations, activity restrictions, or other special needs: _____

_____

_____

I hereby acknowledge that Section IV has been completed to the best of my knowledge and hereby recommend _____ ("Recipient") to participate in the Gift of Moments offered by Treasured Time, Inc.

Physician's Signature: _____ **Date:** _____

Physician's Contact Information:

Last Name: _____ First Name: _____ M.I.: ____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: (_____) _____-_____

Work: (_____) _____-_____

Cell Phone: (_____) _____-_____

Fax: (_____) _____-_____

E-mail Address: _____

SECTION V
HIPAA RELEASE FORM

TO: _____
(Physician)

_____
(Physician's Address)

_____
(Physician's Telephone Number)

RE: _____
(Patient – Print Name Legibly)

_____
(Patient's Date of Birth)

I authorize Griffin Hospital and the Physician identified above the use and disclosure, to Treasured Time, Inc. ("TT"), 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 TT's services; and (b) if so, whether his/her desired Gift of Moments is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to TT forms that TT may require, including forms relating to Patient's medical eligibility, with regards to the requested Gift of Moments and medical consideration 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 TT.

Purpose for which information will be used/disclosed: To enable TT to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a Gift of Moments granted by TT and, if so, whether the requested Gift of Moments is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires ninety days (90) from the date the authorization is signed or Patient's Gift of Moments has been granted by TT or a final determination has been made that Patient is not eligible to receive a Gift of Moments.

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 regulation, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

_____	_____	_____
Patient Name	Patient Signature	Date
_____	_____	_____
Patient Representative	Patient Representative Signature	Date

Section VI
Referral Candidate's Statement

I hereby warrant and represent that the information provided in Sections I -V of the Gift of Moments Referral Package is accurate. I consent to be contacted by Treasured Time, Inc. ("TT"), via phone, fax, mail, and/or e-mail at the numbers/addresses provided by me or my Referral Agent in regard to a Gift of Moments offered by TT.

Referral Candidate Signature: _____

Print Name: _____

Date: _____