Treasured Time - Gift of Moments Application Package

Applicant Instructions:
All Gift of Moments applicants must meet all the eligibility requirements listed below prior to applying.

Eligibility Requirements:
All applicants must:

1. have a life threatening illness;

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

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

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

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

Applicants will be contacted after the Gift of Moments Application Package, including all forms, has been received.

Please submit the completed Application Package by email to: Cassandra@treasuredtime.org
or fax to: 475-675-2940.

If unable to email, please send to: Treasured Time, Inc
Family Relations
PO Box 152
Seymour, CT 06483

Please note: A limited number of applications are approved each year. Your application may not be approved even if all of the criteria are met.

You will receive a response from us within 30 days.

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

Section I – Treasured Time Application Form

Application Date: _____

Applicant's Information: (As listed on driver's license)

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

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Best method of communication: Text, Email or Phone: _____ Fax: _____

Spouse Information: (if applicable)

Spouse's Last name: _____ First Name: _____ M.I. _____

Spouse's Date of Birth: _____ Spouse's Cell Phone: _____

Email: _____

Children's Information: (must have at least one (1) child between the ages of three (3) and eighteen (18) at time of application. Only one child needs to meet the age requirement.

Name: _____ Date of Birth: _____ Gender:

Name: _____ Date of Birth: _____ Gender:

Name: _____ Date of Birth: _____ Gender:

Name: _____ Date of Birth: _____ Gender:

Name: _____ Date of Birth: _____ Gender:

Name of person referring applicant, if other than treating physician: _____

Referral agent affiliation (i.e., name of school) _____

Referring agent phone: _____ Email: _____

Section II - My Story

Applicant's Last Name: _____ First Name: _____

1. **Your Story -** Please provide a narrative of your story and describe why "Gifts of Moments" with your family is so important to you, describe any financial hardships, and anything else you would like to share about your family or illness with the voting board. Attach additional page if necessary.

2. What do you and your family enjoy doing together? _____

_____

_____

3. If you're voted in as a Treasured Time family, what "Gift of Moments" would you like to create with your family? _____

_____

_____

4. When would you like to travel? _____
5. When was the last time you traveled, where did you travel and with who?

_____

6. Do you have any pending travel plans? If so, when, where and with who?

_____

7. Are your family and friends aware of your diagnosis? Yes
8. If you are chosen to create a Gift of Moments, do you agree to submit 25 emails of we can contact regarding your Gift of Moments? Yes
9. Please attach a list of community affiliations/supports and their contact information (i.e., church, civic groups, sports groups, community organizations, etc.) that that we can contact if you are chosen for a Gift of Moments.
10. Hometown newspaper, Patch, blogs, etc. that we can send announcements to if you are chosen for a Gift of Moments: _____

_____

Patient's/Applicant's Occupation: _____

Patient's/Applicant's Employer: _____

Spouse's Occupation: _____

Spouse's Employer: _____

Children's School District/Schools: _____

Please note that your contacts <u>will only</u> be contacted if you are chosen for a Gift of Moments.

Section III – Applicant Statement

I hereby warrant and represent that the information provided in the completed Treasured Time Gifts of Moments Application Package is accurate. I consent to be contacted by Treasured Time, Inc. (TT) in regard to my application for a Gift of Moments offered by TT.

Applicant's Printed Name _____

Applicant's Signature: _____

Date: _____

HIPAA RELEASE FORM Attached

Initial Contact Preference:

Cell Phone: (____) _____-_____

Text: (____) _____-_____

Home Phone: (____) _____-_____

Email: _____

For office use only:

Date application received: _____ Date received by family relations: _____

Section IV – HIPAA Release Form

TO:

_____

(Physician)

_____

(Physician's Address)

_____

(Physician's Telephone Number)

RE: _____ _____

(Patient – Print Name Legibly) (Patient's Date of Birth)

I authorize _____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 one year 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 V - Physician/Medical Information Form

Instructions: This form must be completed and signed by the applicant's treating physician.

Patient's Name: _____

Physician's Name: _____

Hospital/Center/Organization Affiliation: _____

Diagnosis: _____

_____

Date of Diagnosis: _____

Do you feel there is an urgency of **less than six months** for this patient's participation in Gifts of Moments? If yes, Treasured Time will contact your office for further information and recommendations.

☐ yes ☐ no

Physician's Phone: (____) _____-_____ Physician's Fax: (____) _____-_____

Physician's E-mail Address: _____

Contact Information: (If other than physician, please complete best person in treating doctor's office to contact should we need additional information.)

Last Name: _____ First Name: _____

Position: _____

Phone: (____) _____-_____

I hereby recommend the patient listed above as an applicant for Gift of Moments offered by Treasured Time, Inc.

Physician's Signature: _____

Date: _____