# *Medical Assistance Award Application*

**Applicant Information**

**TO BE ELIGIBLE, EMPLOYEE/APPLICANT MUST HAVE HEALTH INSURANCE COVERAGE.**

1. Is this your first time applying? ☐ Yes ☐ No  2. What type of assistance is needed? ☐ Surgical ☐ Dental ☐ Serious/Non-Surgical

Today's Date: ____/____/____ *Month/Day/Year*  Employer Name: _____

Average hours worked per week: _____

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

Patient Name
(if different from above): _____
*First Name* *M.I.* *Last Name*

DOB: ____/____/____ *Month/Day/Year*  Age: _____

Mailing Address: _____
*Mailing Address* *City* *State* *Zip Code*

Email: _____

Phone: _____ Alternate Phone: _____

How do you prefer to be contacted about your award? ☐ *By Phone* ☐ *By Email*

Health Insurance Provider: _____ Dental Insurance Provider: _____

*All medical awards must be eligible for insurance. How much are your estimated costs (after insurance)? $ _____

Name of Treating Physician: _____ Phone: _____

*To ensure timely review, required documents must be submitted together at time of application.
All requests for support must include the following documents in advance of application review. Please submit and check each of the required items listed below:

1. ☐ Completed & signed Medical Assistance Award Application (this form).
2. ☐ Employee Verification Letter of Employment
3. ☐ Official document describing the estimated costs patient will be responsible for and what portion is eligible for insurance. This must show the dates of service and cost breakdown.
4. ☐ 'Ohana Medical Treatment Plan
5. ☐ Medical Reimbursement Request Form
6. ☐ All original bills, receipts, and hospital discharge paperwork.

*If no documentation is provided to the foundation within 3 months, your application will be considered voided.

**Please read and sign the following:**

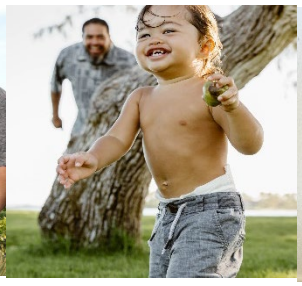
I hereby certify that I have received the attached copy of the Hualalai Ohana Foundation's Statement of Privacy Practices and that the above information is accurate. By signing, I allow the Hualalai 'Ohana Foundation and/or their representatives to obtain a confirmation of diagnosis, prognosis, and any necessary billing information from my medical and/or dental providers listed above in order to assist me on my behalf if necessary.

Signature: _____ Date: _____

**Employee signature or authorized representative**
**Upon receipt of your application, the foundation will contact you within two weeks to inform you of their decision.**
***To ensure timely review, required documents must be submitted together at time of application.**

For Office Use Only:
APPROVED/NOT APPROVED  DATE:

P.O. Box 5227, Kailua-Kona, HI 96745  (808) 325-4701

# ‘Ohana Medical Treatment Plan

*This section to be completed by applicant only:*

Is this person covered under the employee’s health insurance plan? ☐ YES ☐ NO

Patient Name: _____

*First Name* *M.I.* *Last Name*

DOB: ___/___/___ Age: _____

*Month/Day/Year*

Mailing Address: _____

*Mailing Address* *City* *State* *Zip Code*

Email: _____

Phone: _____ Alternate Phone: _____

*This section to be completed by physician or dental provider office only:*

The purpose of this form is to collect the information needed to qualify the applicant above for financial support through the Hualalai ‘Ohana Foundation Medical, Dental and Serious Medical Award Programs. In order to review all requests for support, we require a diagnosis and prognosis in the form of a treatment plan. Please complete the information below and return to applicant/patient to include with their application for financial support.

| Medical / Dental Diagnosis (Physician or Dental Office to complete this section) OR Attach formal treatment plan |
|---|
| |
| Medical Prognosis / Recommended Treatment Plan OR Attach formal treatment plan |
| |

Medical / Dental Provider Name: _____ Phone: _____

Physican/Doctor’s Office Signature: _____ **Date:** _____

# Medical Expense Reimbursement Form

Awardee/Patient Name: _____

Phone number and Email: _____

Medical Award Type: _____

**Medical Purpose - Diagnosis/Prognosis:**

## Itemized Expenses

| NUMBER * | DATE OF SERVICE | IS THIS A BILL OR A RECEIPT? | DESCRIPTION | CATEGORY | COST | NOTES |
|---|---|---|---|---|---|---|
| 0 | 00/00/0000 | Sample Receipt | Sample Medical Hospital | Surgical procedure | $0 | |
| | | | | | | |
| 1 | | | | | | |
| | | | | | | |
| 2 | | | | | | |
| | | | | | | |
| 3 | | | | | | |
| | | | | | | |
| 4 | | | | | | |
| | | | | | | |
| 5 | | | | | | |
| | | | | | | |

Instructions:

**Please itemize bills and receipts in numerical order. We do not accept incomplete reimbursement requests or unitemized Receipts must be itemized and taped to an 8.5x11 sheet of paper to match number column above.*
*If a bill, we will pay provider on your behalf. If a receipt, we will reimburse you.*
*We do not reimburse for cosmetic surgeries, autopsies, funerals, gratuities, clothing, or expenses unrelated to the medical case/award.*

**SUBTOTAL** $ -

**TOTAL REIMBURSEMENT** $ -

**Don't forget to attach receipts!**

**Employee Signature** Date

**Approval Signature** Date

*FOR OFFICE USE ONLY:*

**PATIENT AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient's Name_____Date of Birth_____

I request and authorize the recipient of this Patient Authorization to release healthcare information, including, but not limited to the financial responsibility for treatment of my medical condition, such as medical bills, prescription expenses, payment of outstanding invoices, future medical expenses, denial of healthcare coverage, or other medical and financial information to:

Hualalai 'Ohana Foundation
P.O. Box 5227
Kailua-Kona, HI 96745
(808) 325-4701

This request and authorization applies to:

Healthcare and/or medical expense information relating to the following treatment, condition, or procedure:

_____

Signature of patient or patient's authorized representative Date Signed

*I may revoke this authorization to the extent allowed by law. If I do, I understand that this office may have already released information about me after I gave permission. I can write a letter to this office to revoke my authorization and specify the person(s) that no longer should receive this information. I must sign and date the letter.*

*If the authorized parties listed above gives out the information that I wanted released, I understand that they no longer have control over protecting its privacy.*

# HUALALAI ‘OHANA FOUNDATION

## Statement of Privacy Practices

***(Please keep this document for your files.)***

Our organization is dedicated to protect the privacy rights of our award recipients and the confidential information entrusted to us. The commitment of each foundation employee is to ensure that your health information is never compromised is a principal concept of our mission. We may amend our privacy policies and practices, but will always inform you of any changes that might affect your rights.

This Statement of Privacy Practices describes how we may use and disclose your protected health information to carry out our mission of providing support for medical expenses.

Upon acceptance of your case, the foundation Executive Director or the foundation’s administrative coordinator; will provide you with support and act as your advocate. The Executive Director or coordinator will ask you to sign our Patient Authorization Form. This gives your coordinator the necessary documentation to access healthcare information relating to your treatment and/or condition directly from your treating physician.

Your coordinator will only share this information with the foundation Executive Director and/or Medical Committee if absolutely necessary; specifically, if you (1) have reached the reimbursement limit and continued support requires a committee vote; or (2) are being considered for an Exceptional Circumstances Award. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employee(s) are trained to make certain that the confidentially of your records is always protected. Our privacy policy and practices apply to all former, current, and future award recipients, so you can be confident that your protected health information will never be improperly disclosed or released.

The Medical Mission of the Hualalai ‘Ohana Foundation is to alleviate the extraordinary medical expenses of those Hualalai community employees and their families facing serious and potentially life threatening medical emergencies or disabling conditions requiring surgery. Our goal is to be of assistance to you and your family during this time of crisis. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

P.O. Box 5227 Kailua-Kona, HI 96745 (808)325-4701 office (808) 325-8228 fax