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: _____

Start Date: _____

Job Title/Department: _____

Average # of hours worked per week: _____

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

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

What is the patient's relationship to employee (self, spouse, child): _____

If the patient name above is not you, can you provide documentation to prove that he/she is your dependent? ☐ Yes ☐ No

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

Mailing Address: _____
Mailing Address *Apt # or Unit #* *City* *State* *Zip Code*

Email: _____

Phone: _____ Alternate Phone: _____

Health Insurance Provider: _____ Dental Insurance Provider: _____

*All medical award applicants must have 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. ☐ 'Ohana Medical Treatment Plan (Payment Plan Agreements are not acceptable as a Medical Treatment Plan*)
3. ☐ Employee Eligibility Verification Form
4. ☐ Patient Authorization Form
5. ☐ Explanation of Benefits (EOB): An explanation of benefits (EOB) is a document provided to you by your insurance company after procedure for which a claim was submitted to your insurance plan. (for Dental awards only)
6. ☐ Medical Expense Reimbursement Form
7. ☐ 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. 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: _____

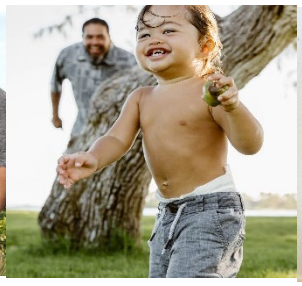
Employee signature or authorized representative

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:

HUALALAI
'OHANA
FOUNDATION

'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
Recommended Treatment Plan / Medical Prognosis OR Please attach formal treatment plan

Medical / Dental Provider Name: _____ Phone: _____

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

Revised 06/07/2023

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) 325-8178

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.

Employee Eligibility Verification Form	
This section to be completed by employee:	
Employee First & Last Name:	
Job Title:	
Department:	
This section to be completed by employer:	
Date First Employed:	
This employee is employed at: Please check √ one (1): ☐ Four Seasons Hualalai ☐ Hualalai Investors, LLC ☐ Resort Contractor: Name of Company: _____	This employee's employment status is Please √ check one (1)): ☐ Active – Full-Time ☐ Active – Part-Time ☐ Active – Casual ☐ Other Status _____
Average # of hours worked per week: _____	
Signature: _____Date: _____ (Signature of Verifier) Print Name of Verifier: _____ Verifier Position Title: _____ at _____ Name of Company: _____	

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: