	ſ	Aedical Assis	tance Awa	ard Application	Tri	
					HUALALAI OHANA FOUNDATION	
		Applicant Informa	ation			
TO BE ELIGIBLE, EMPLOYE	EE/APPLICANT MUST HA	VE HEALTH INSURANCE CO	OVERAGE.			
1. Is this your first time ap	plying? 🗌 Yes 🗌 No	2. What type of assista	nce is needed? 🗌 Su	ırgical 🗌 Dental 🗌 Serious/Nor	n-Surgical	
Today's Date:	/ /	/ Employe	r Name:			
roudy s bute.	N	onth/Day/Year		t Date:		
		Aver	rage # of hours work	red per		
	Job Title/Department:					
			Job Title/Depar	rtment:		
Employee Name:	First Name	M.I.	La	ast Name		
Patient Name						
(if different from above):						
	First Name	M.I.	Lc	ast Name		
DOB:		Age:				
	Month/Day/Year	0-				
Mailing Address:	Mailing Address	City	State	Zip Code		
	Walling Nauress	City	State	210 0000		
Email:						
Phone:			Alternate Phone:			
How do you prefer to be c	contacted about your aw	ard? 🗌 By Phone	🗌 By Email			
Health Insurance Provider	··	Dental	Insurance Provider:			
*All medical awards must	be eligible for insurance	. How much are your estim	nated costs (after insu	irance)? \$		
Name of Treating Physicia	in.		Phor	<u></u>		
		ust be submitted together a				
All requests for support m	nust include the followin	-		Please submit and check each of	the	
required items listed belo		rd Application (this form).				
2. Employee Verification						
			sible for and what po	rtion is eligible for insurance.		
This must show the dates		kdown.				
4. 'Ohana Medical Trea 5. Medical Reimbursen						
6. All original bills, rece		rge paperwork.				
*If no documentation is provided to the foundation within 3 months, your application will be considered voided.						
Please read and sign the f			Statement of Data and D	tions and that the share 's formall'	0.001-1-1-	
By signing, I allow the Hualalai	'Ohana Foundation and/or t		confirmation of diagnosis	tices and that the above information is s, prognosis, and any necessary billing i		
Signature:				Date:		
Employee s	signature or authorized re	presentative				
				o 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 AP			DATE:			



'Ohana Medical Treatment Plan

This section to be completed by applicant only:

Is this person covered under the employee's health insurance plan? \Box YES \Box NO

Patient Name:						
	First Name		M.I.	Las	t Name	
DOB:	/	/	Age:			
	Month/Day/Y	'ear				
Mailing Address:						
	Mailing Addre	255	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:

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.



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 V one (1): Four Seasons Hualalai Hualalai Investors, LLC Resort Contractor: Name of Company: 	This employee's employment status is Please V check one (1)): Active – Full-Time Active – Part-Time Active – Casual Other Status					
Average # of hours worked per week:						
	Date:					
Print Name of Verifier:						
Verifier Position Title:at						
Name of Company:						

Covid-19 Vaccination Verification Form

etc.



Section 1: Self-Certification of COVID-19 Vaccination Status

If you certify that you have received an approved vaccine and that your COVID-19 vaccination status is current (Section 1), please complete additional information about your vaccination status.

I certify that I have received **at least one shot** of an approved vaccine and that my COVID-19 vaccination status is current. I understand that I may be expected to provide supporting documentation to this effect immediately upon request. I further understand that for purposes of this certification, I am only considered fully vaccinated two weeks

after completing the second dose of a two-dose COVID-19 vaccine (e.g., Pfizer or Moderna) or two weeks after receiving a single dose of a one-dose vaccine (e.g., Johnson & Johnson/Janssen) and that I should not check this box and certify myself until I am fully vaccinated.

I certify that I am fully vaccinated and that my COVID-19 vaccination status is current. I understand that I may be expected to provide supporting documentation to this effect immediately upon request. I further understand that for

- purposes of this certification, I am only considered fully vaccinated two weeks after completing the second dose of a two-dose COVID-19 vaccine (e.g., Pfizer or Moderna) or two weeks after receiving a single dose of a one-dose vaccine (e.g., Johnson & Johnson/Janssen) and that I should not check this box and certify myself until I am fully vaccinated.
- I certify that I qualify for a medical exemption and have not received a COVID-19 vaccine, nor do I plan to. I understand that I may be expected to provide supporting documentation to this effect immediately upon request.

Please provide the following information	on:			
Manufacturer of your COVID-19 vaccine:	🗆 Pfizer	🗆 Moderna	□ Johnson & .	Johnson/Janssen
Date Received 1st Dose :				
Date Received 2nd Dose:				
Date Received Booster (if applicable): Location of vaccination received:				
Location of vaccination received:				
Facility (if known):				
City:				
State:				
Section 2: Self-Attestation of Accuracy of	of Inform	ation Provi	ded	
I confirm that the information I have provid that violations of this policy, including dish application.				
Signature:			Date	
Print Name:				
Section 3: Attachments				
If you certified that you have received an appro	ved vaccin	e in (Section), you will need	to attach a photocopy of your
COVID-19 vaccination proof. An example of pro	of is a COV	ID-19 Vaccinat	ion Record Car	d, letter from a healthcare provider,

Medical Expense Reimbursement Form

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: SUBTOTAL					\$-	
*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 provide 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.

Employee Signature

Date

Approval Signature

FOR OFFICE USE ONLY:



Don't forget to attach receipts!

Date