





# '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: \_\_\_\_\_

**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:

\_\_\_\_\_

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



# Covid-19 Vaccination Verification Form

## 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:

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:

Facility (if known): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

## Section 2: Self-Attestation of Accuracy of Information Provided

I confirm that the information I have provided is accurate and truthful to the best of my knowledge. I also understand that violations of this policy, including dishonesty, may subject me to rejection of my Hualālai 'Ohana Foundation application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## Section 3: Attachments

If you certified that you have received an approved vaccine in (Section 1), you will need to attach a photocopy of your COVID-19 vaccination proof. An example of proof is a COVID-19 Vaccination Record Card, letter from a healthcare provider, etc.

# 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:**