





# '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:

\_\_\_\_/\_\_\_\_/\_\_\_\_

*Month/Day/Year*

Age:

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) 325-8178

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**

**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  $\checkmark$  one (1):

- Four Seasons Hualalai
- Hualalai Investors, LLC
- Resort Contractor:  
Name of Company: \_\_\_\_\_

This employee's employment status is

Please  $\checkmark$  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:**