Dental Surgery Assistance Award Application

Is this your first time applying for this award?
YES NO
How did you hear about this award?
Program Fair Ambassador HR
Website Other: _____

Name of Hualalai Community Employee: _____

Name of patient (if different from above): _____

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

Name of employer (circle one): Hualalai Investors, LLC Four Seasons Resort Resort Vendor_____

Start date with employer: _____ Avg. hours per week: _____

Address: _____

E-Mail: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Health Insurance Provider: _____ Dental Insurance Provider: _____

Please describe the medical situation (diagnosis):_____

_____

Brief description of treatment plan (prognosis):_____

_____

How long will you be off of work for recovery? _____

Will you have to travel for treatment? If so, to where? _____

How much are your estimated costs (after insurance)? _____

Name & Phone of Treating Physician(s): _____

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 the Patient Authorization form, 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.

_____ _____
Applicant signature or authorized representative Date

Upon receipt of your application, the foundation will contact you within two weeks to inform you of their decision.

APPROVED/NOT APPROVED 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:

Erlinda Borges
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.

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.