THE Guiding Hand FOUNDATION

NOMINATION FORM

Are you Nominating as: Month Application Submitted:

☐ On My Own Behalf ☒ Nominating a Relative/Friend ☐ Healthcare Professional Nominating a Patient

1.

Nominator's Last Name:	Nominator's First Name:	M.I.	Relationship to Patient:
Nominator's Phone Number: ( )	Nominator's City/State:		

2. PATIENTS INFORMATION *(Please Print)*

Patient's Last Name:	Patient's First Name:	M.I.
Date of Birth: Age:		
Address:	City:	State: Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Email:		

Is "patient" aware that they are being nominated for assistance? ☐ Yes ☐ No	Can we inform the patient as to who nominated them? ☐ Yes ☐ No

Describe patients current employment/work situation: (Check all that apply.)	☐ Full-Time ☐ Part-Time ☐ Retired ☐ Short-Term Disabled/ Medical Leave ☐ Long-Term Disabled ☐ Unemployed ☐ Student ☐ Other: _____

Current Employer:	Current Position:	How long with company:
Total number of people in the household:	Describe the patient's diagnoses:	

3. THE STORY & THE NEEDS *(Please Print)*

Please briefly tell us the story… include things such as your everyday life, financial situation before and after cancer diagnosis, and identify the bills, products, or services you need the most help with (please use additional paper as needed):

_____

_____

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** PLEASE CONTINUE TO NEXT PAGE **

4.

Healthcare Provider Last Name: Healthcare Provider First Name: Healthcare Provider Facility:

Healthcare Provider Phone Number: Healthcare Provider Address/City/State:
( )

5. DISCLAIMER & HIPAA AUTHORIZATION

I have read the application, and all instructions. I understand the purpose of The Guiding Hand Foundation (GHF) Grant and fully accept all terms and conditions of the fund, and all other rules, regulations and conditions set forth concerning the fund. In particular, I have read regulations on how the money will be awarded and by signing below I accept these conditions. I hereby certify that the information provided in all parts of this application is fully valid and complete. I am fully aware that by filling out this grant form that it is solely a nomination and that I am not guaranteed any help, financial or educational assistance. I am aware that it may take up to 10 weeks to process my application to its fullest. I understand that the information I provide and that will be gathered will be used only to determine responsibility and concern and will be kept confidential. I further understand that the information which I submit on this application and other forms is subject to verification by the GHF staff, its subsidiaries, affiliates, and organizers. I understand that if any information I have given is determined to be false, it may result in reversing the entire nomination process and/or the approval and I will be liable for the full amount of all charges. My signature authorizes GHF to verify all information provided on this form. I certify that the above information is true and accurate to the best of my knowledge.

Applicant's Printed Name: _____

Date: _____

Applicant's Signature: _____

I am aware that my health care provider may need to be contacted regarding the accuracy of the information provided and to verify my diagnosis. I give permission to the Guiding Hand Foundation Grant committee to contact my health care provider, understanding that the information obtained from my health care provider will not be shared with other parties and is used solely for verification purposes only. By signing below, I give permission to The Guiding Hand Foundation to obtain information from my Healthcare Provider/facility listed above to disclose protected health information that is being used or disclosed for verification of cancer diagnosis and treatment status, in order to qualify for The Guiding Hand Foundation funds. Authorization to contact my Healthcare Provider/facility will expire six months from the date listed below.

Patient's Printed Name: _____

Date: _____

Patient's Signature: _____

6. CONFIDENTIALITY CLAUSE & CONSENT TO USE

The Guiding Hand Foundation considers this application, and its attached information, confidential. The Guiding Hand Foundation shall not use the Confidential Information other than for the purposes of its business with the applicant, and shall disclose it only to its officers, board members, or government agencies on a specific need to know basis. The Guiding Hand Foundation will not disclose, publish or otherwise reveal any of the Confidential Information received from applicant to any other party whatsoever except with the specific prior written authorization of Applicant. By signing below, you give The Guiding Hand Foundation, authorization to speak with the social work department and/or Doctors to verify your situation. By signing below, you do however, give permission to The Guiding Hand Foundation to share your name and story. I hereby consent to the use of any photograph, video or likeness by The Guiding Hand Foundation for purposes of advertising or promoting services. I understand that, as used in this consent, "photograph" or "video" means any photograph, photographic reproduction or video. Occasionally, sponsors, vendors and reporting request progress updates on our program, and how it is making a difference. Your signature grants us permission to share with them the positive impact on your family.

Patient's Printed Name: _____

Date: _____

Patient's Signature: _____

7. FEATURED FAMILY

I hereby consent that my family and our story would be willing to participate as a Featured Family at a future Guiding Hand Foundation event. This includes, but is not limited to, participating in future events and telling my family story.

Patient's Printed Name: _____

Date: _____

Patient's Signature: _____