HOSPICE & PALLIATIVE CARE FOUNDATION

Adult HPCF Program
Small Gift Request Form

Name of Adult Patient (First and Last Name): _____

Adult Patient's Date of Birth: _____

Adult Patient's County: _____

Adult Patient's Gender: _____Adult Patient's Ethnicity: _____

Is the patient a veteran or spouse of a veteran? _____

Physical Address of Adult Patient (Street, City, State, and Zip) *(No Post Office Box)*:

_____

_____

Email Address (*For eCard Requests Only*): _____

Please Note: to ensure that eGift Cards are received and accessible by the patient, we ask that email notifications are opened and verified within two weeks of the date of purchase. After this timeframe, we may not be able to rectify issues in accessing an eGift Card's value. Due to vendors' refund and exchange policies, we are not able to replace eGift Cards.

Small Gift Requests Only:

Item (s) Requested: _____

Please provide a link for the specific item or items here or send a separate email to info@hpcfoundation.org:

_____

Vendor Name: _____

Additional Delivery Instructions: if this small gift request needs to be sent to an address, or email address for an eGift Card, to someone other than the patient, please provide a statement of explanation on the lines below.

_____

_____

DISCLOSURE STATEMENTS – PLEASE READ CAREFULLY BEFORE CONTINUING AND SIGNING:

As a public nonprofit, 501(c)(3), organization, we cannot provide gifts, awards, and/or relief funds to individuals that are not a United States Citizen. Accordingly, individuals receiving gifts, awards, and/or relief funds that are funded by *The Hospice & Palliative Care Foundation* must either be a United States Citizen or a Naturalized United States Citizen.

By signing below, the patient agrees to the foregoing disclosures and is attesting they are a United States Citizen or a Naturalized United States Citizen. Individuals that provide false information in the foregoing sections or is found not be a United States Citizen or a Naturalized United States Citizen may be subject to criminal and/or civil penalties based on the laws of South Carolina. In addition, if the patient received assistance completing this application from a responsible party (see below) or from a member of their healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on their behalf.

Patient's Signature: _____ Date: _____

If the patient is unable to sign or if deceased, **STOP, DO NOT SIGN, the person completing the request (not the hospice team member) will need to complete the following information. This information is for informational purposes only.*

If the responsible party received assistance completing this application on behalf of the patient by a member of the patient's healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on the patient's behalf.

Responsible Party's Signature: _____Date: _____

Name of Responsible Party Completing Forms: _____

Address of Responsible Party Completing Forms:

_____ _____

Street City

_____ _____ _____

State Zip Code Phone

Email: _____

Relationship to Patient: _____

Hospice Team Member Please Sign Below In The Box:

For Administration and Accounting Use Only:

Level One (Hospice Worker):_____**Date:**_____

Level Two Approver (Associate Director):_____**Date:**_____

Level Three Approver (Accounting):_____**Date:** _____