Pediatric HPCF Program
Small Gift Request Form

****PLEASE PRINT CLEARLY & LEGIBLY – APPLICATIONS THAT ARE NOT CLEAR WILL BE RETURNED****

Name of Pediatric Patient (First and Last Name): ____

Pediatric Patient's Date of Birth: ____

Pediatric Patient's County: ____

Pediatric Patient's Gender:______________________ Pediatric Patient's Ethnicity: ___________________

Is the pediatric patient a veteran or child of a veteran? ____

Physical Address of Pediatric Patient (Street, City, State, and Zip) *(No Post Office Box)*:
(Do Not Forget Extension i.e. Road, Street)

____

____

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: ____
Note: please indicate "physical" or "eGift" card, if requesting a gift card.

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.

____

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Required: if requesting a gift card, please check one of the boxes below to indicate how the gift card will be used. If the "quality of life" or "other" box is checked, please provide a short description of how the gift will be used in the space below. This must be completed for an application to be approved and funded.

_____ Food _____ Clothes _____ Gas _____ Utility Bill Under $100.00

_____ Prescription Copay (s) _____ Doctor Visit Copay (s) _____ Transportation

_____ Quality of Life Item (Please Explain Below) _____ Other (Please Explain Below)

____

____

MEDIA RELEASE SECTION (OPTIONAL) –

This section *only* needs to be completed if a photograph or photographs will be submitted to the *Hospice & Palliative Care Foundation* for use in marketing materials. At the *Hospice & Palliative Care Foundation*, we respect the privacy of our patients, and therefore; we will never sell your information or picture (s), and we will never release your name in any of our marketing materials. **All photographs must be submitted to our general information email at info@hpcfoundation.org. This section is not required for approval and funding. If the patient/responsible party does not sign at the time of the application submission, but later decides to submit a photograph or photographs, please contact us at info@hpcfoundation.org for additional instructions and the appropriate form. DO NOT SUBMIT THIS FORM FOR JUST THE MEDIA RELEASE.**

I, ______________________________________, grant the *Hospice & Palliative Care Foundation*, on behalf
(Parent/Legal Guardian/Patient Over Age 18)

of ______________________________________, permission to use any photograph (s) submitted to
(Patient Under Age 18/Patient Over Age 18)

info@hpcfoundation.org for any legal use, including but not limited to, publicity, copyright purposes, illustration, advertising, flyers or other printed materials, web content, and grant proposals. Furthermore, I understand that no royalty, fee, or other compensation shall be become payable to the patient or to my family by reason of such use.

Signature: ____ Date: _____________

Email: ____ Phone: ___________________________

DISCLOSURE STATEMENTS – PLEASE READ CAREFULLY BEFORE CONTINUING AND SIGNING:

Individuals requesting gifts and relief funds on behalf of a minor patient must be the patient's parent (s) or legal guardian (s). We cannot accept requests from family members or friends unless they have been granted legal guardianship by a family court judge.

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 parent (s) / legal guardian (s) agrees to the foregoing disclosures. They are attesting that they are the patient's parent (s) or legal guardian (s). They are attesting that their minor child (under the age of eighteen) is a United States Citizen or a Naturalized United States Citizen. Individuals that provide false information in the foregoing sections, or is found not be the patient's parent (s) or legal guardian (s), or the patient is found not to 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.

If the parent (or legal guardian) or the patient 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.

Parent / Legal Guardian Signature:____Date: __________
Note: if the pediatric patient is over the age of eighteen (18) **and is legally competent to sign on their behalf, **STOP, DO NOT SIGN HERE,** they will sign below.*

Patient Signature: ____Date: __________

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:** __________