



**Technology for Hope Program
Overview of Program and Agreement
Technology Request Form**

The *Technology for Hope Program* has been established by the *Hospice & Palliative Care Foundation* to provide equipment and resources to pediatric patients on hospice or palliative care services that can benefit from their use for therapeutic purposes and/or telemedical support such as communication with the patient's health care team. The goal of this program is to enhance the quality of life for a child on a hospice or palliative care services.

The devices available through this program may include a new or refurbished *Fire HD Tablet* or *Apple iPad*, or an equivalent device from another vendor. In addition, a technology specific gift card up to \$50.00 may be requested to purchase additional applications. **Note: the entire value of these items, plus accessories, cannot exceed \$350.00. Please read the following agreement carefully before proceeding with this application and signing.**

Agreement:

As a condition to receiving a device and any accessories including, but not limited to, screen protectors, cases, and technology specific gift cards, the undersigned patient or the patient's parent (s) / legal guardian (s) agrees to and is bound by the following terms, conditions, and obligations:

1. Description of Equipment – based on availability, the patient will select either a *Fire HD* or an *Apple iPad*, and a charger. The patient can elect to receive their selected device with a screen protector and/or case, however; this may result in a different device model in order to keep the total amount provided under the maximum gifted amount of \$350.00*.
2. Use of Equipment – a device is provided for the sole benefit of the patient, not the patient's siblings and/or family, and is intended for therapeutic purposes and/or telemedical services with the patient's care team. The device should not be used for any illegal or unethical purposes.
3. Downloading Applications – since the purpose of this program is to provide the patient with therapeutic and telemedical support, only those applications that pertain to the patient's plan of care and telemedical support should be installed on the device.
4. Damage, Theft, or Loss – we are under no obligation to replace a damaged, stolen, or lost device, and any accessories requested once the application has been approved and funded.
5. Warranty – we will not provide any type of warranty or guarantee in addition to the manufacturer's warranty or guarantee for the device, requested accessories, and/or requested applications. We will provide a gift receipt for all items requested and awarded in the event the patient or the patient's parent (s) / legal guardian (s) needs to contact the original merchant (aka seller) or manufacturer regarding any warranty or guarantee questions and concerns. **Note: neither the *Hospice & Palliative Care Foundation* nor any member of the patient's hospice or palliative care team will be able to contact the merchant and/or manufacturer on behalf of the patient or the patient's parent (s) / legal guardian (s).**
6. Limitation of Liability – we will not have any liability, responsibility, or obligation for any harm, expenses, costs, and/or damages incurred by the patient, or any other third party; or if the device,

requested accessories, and/or requested applications are damaged, defective, not suitable for the patient's use, or any third-party purposes or intended use. We will not be liable for any direct, indirect, special, incidental, or consequential damages arising out of or under this agreement, however caused, whether in contract, tort, or otherwise.

7. Choice of Merchant – it is at the discretion of the *Hospice & Palliative Care Foundation* to choose the merchant for the purchase of the selected device, applications, and/or accessories.
8. Connectivity and Data Plan Requirements – since the device will not come with a data plan or any type of mobile service plan, it will be the responsibility of the patient to have a strong, reliable connection to the internet, Wi-Fi, or comparable data plan with a mobile service provider. Please check with your mobile service provider before finalizing your selection as devices cannot be returned and exchanged once an application has been approved and funded.
9. Reliable Shipping Address – a reliable, physical address, no post office box, is required that is capable of receiving deliveries from various carriers including, but not limited to, *Amazon, FedEx, UPS*, and the *United States Postal Service*. **Note: equipment and accessories cannot be sent to any member of the patient's healthcare team.**
10. Maximum Costs* – the total maximum cost for the device, applications, and/or accessories cannot exceed \$350.00 per patient.

By signing below, the patient agrees to and understands the previous terms and conditions, and accepts responsibility for the device and any accessories selected during the purchase process. If the patient is a minor (under the age of 18), or the patient is not legally competent to sign, the parent (s) / legal guardian (s) must agree to the terms and conditions, and accept responsibility for the device and any accessories selected during the purchase process. In addition, if 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.

Signature Lines for Pediatric Patients Age 18 or Older:

I certify that I am eighteen (18) years of age or older, and that I am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

(Signature)

(Date)

(Printed Name)

ADDITIONAL 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) 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.

Signature Lines for Parent (s) or Legal Guardian (s):

Note: this is for patients under the age of eighteen (18) and/or incompetent to contract in their own name

I hereby certify that I am the parent (s) or legal guardian (s) of _____, and do hereby give consent without reservation on behalf of this person.

(Parent/Guardian Signature) (Date)

(Printed Name)

Patient/Patient's Family Section - -

Pediatric Patient's Name: _____
(First and Last)

Pediatric Patient's Address: _____
Street

City State Zip Code

Patient's County

Patient's Date of Birth Patient's Gender

Patient's Ethnicity Is this patient a veteran or a child of a veteran?

Pediatric Patient's Parent (s) / Legal Guardian (s) Name (s): _____

Parent (s) / Legal Guardian (s) Phone Number: _____
(with area code)

Parent (s) / Legal Guardian (s) Email Address: _____

Technology Request Section - -

Item Requested (Only Check One):

_____ Fire HD 8 Kids or Equivalent Model (32GB)
(Recommended for ages three to seven years of age)

_____ Fire HD 10 or Equivalent Model (32GB)
(Recommended for anyone over the age of twelve)

_____ iPad or iPad Mini, or Equivalent (32GB)

If a new device cannot be purchased, are you willing to accept a refurbished device? ___ Yes ___ No

Accessories Requested: _____ Screen Protector _____ Case _____ Other (Please Explain)

Hospice Team Member Please Complete The Following Page:

Please Check At Least One (1):

What is the desired outcome of this application?

_____ Improve the quality of care through increased access with the pediatric patient's team;

_____ Facilitate therapeutic interventions with pediatric patient;

_____ Allow the pediatric patient and their family to engage in memory making through videography, photography, or other artistic applications;

_____ Normalize play for pediatric patients and support socialization; or

_____ Provide translational services to bridge language barriers between pediatric patients, parents, and their interdisciplinary team.

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:** _____