Pediatric HPCF Program
Fingerprint Charm 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 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)

____

____

Quantity of Fingerprint Charms Requested _______

______ This is a request for a second charm that is in lieu of a small gift.

**Note: the maximum number of charms for this program, per patient, cannot exceed two. Please refer to our policy guidelines.*

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
(Parent/Legal Guardian/Patient Over Age 18)

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

to 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: __________