HOSPICE & PALLIATIVE CARE FOUNDATION

Pediatric HPCF Program
Small Gift Request Form

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)*:

_____

_____

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:

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: _____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: _____