Island Gift of Life Foundation

Application

Date: ____________________
Name: ____
Address: ____
____
Phone: ____
Contact: ____
(if other than self)
Address: ____
____
Phone: ____

Your MedicaI Needs

Provide us with a copy of your physician's description of your medical condition and treatment plan. Include specialist's reports and any other information you think might help us to understand your medical situation.

(It is imperative that the Selection Committee's doctors are able to communicate with your medical team.. Please include the release form allowing them to contact and discuss your medical situation with your physicians.)

Your Uninsured Expenses

Please provide the committee with a copy of your insurance coverage for the condition for which you are seeking funds:

Have you applied for other financial assistance for this condition?

(include funding sources solicited and/or grants received)

If you will, tell us about yourself and the people you live with, your emotional and spiritual supports. Your information will be used only for assessment of your needs to see how we may best respond to your request.

Island Gift of Life Foundation, Inc.

P.O. Box 532
Shelter Island Heights, New York 11965

Dear Friend:

If you are a resident of Shelter Island, Southold, East Hampton or Southampton with a life threatening illness and need financial assistance for uninsured medical and collateral expenses, we encourage you to make an application to the Foundation

Please, choose and call on of the Island Gift of Life Advocates: The Reverend Dr. Dan Harris 749-0770, Fr. Peter DeSantis 749-0001 or Pastor Bill Grimbol 749-0805 or any other person whom you would feel comfortable using as your advocate. Your advocate will meet with you in person to discuss your situation and to 'assist you with your application materials in strict confidence. Of course, if you prefer, we would be happy to work directly with you if you wish not to utilize an advocate.

You or your advocate will present your needs to the Selection Committee, which is currently made up of a medical doctor and two Board members. This committee will discuss your application materials. If the Committee doctor needs additional medical information, the doctor will explain the need and, with your permission, contact the necessary medical personnel.

The Selection Committee will decide if you meet the criteria for assistance. If so, they will submit only your case number to the Gift of Life Board of Directors for allocating available funds to assist you and your support system. Funds available for grants will be determined by the generosity of the benefactors and donors, and the number of approved applications received.

The Foundation Board will not see any of your application materials. The specifics of your application will only be disclosed to the Selection Committee members.

We are interested in you as a whole person; we respect your privacy ~ you are not just a diagnosis to us. We promise to carefully consider your request and respond as quickly as possible.

Thank you in advance for asking us to help.

Island Gift of Life Foundation, Inc.

P. O. Box 532
Shelter Island Heights, New York 11965

*Date:*____________________

*Patient Name:*___________________________________ *Date of Birth:*________________

*Insurance Carrier:*______________________________ *Policy Number:*____________________

Authorization for Release of Medical & Insurance Records

I am aware that my medical records may have reference to a psychiatric, drug or alcohol problem and this authorization is intended to include permission to release any information pertaining to my treatment for any such problems, if contained in my medical records.

By authorizing the release of my medical or psychiatric records, I hold the Island Gift of Life Foundation, Inc., its physicians, agents and employees harmless from any consequences which I may suffer directly or indirectly as a result of the release of such records.

I understand that I can revoke this release at any time upon written notification to the Island Gift of Life Foundation, Inc. except to the extent that the Island Gift of Life Foundation, Inc. may have already released records in reliance upon this release, unless revoked, this release shall be in effect for (3) *months from the date I sign this form.*

____
Witness

____
Patient's Signature or signature of parents, guardian or other person authorized to consent for patient if a minor (under 18) *or otherwise unable to give consent.*

____
Date Signed

____
Print Name (patient)

____
Relationship to Patient

If drug abuse or alcohol records are involved, this information is disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 *CFR Part* 2) *prohibits re-- disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information will not be sufficient for this purpose.*