Rob Schorling Memorial Fund

Assisting families dealing with Leukemia

APPLICATION

Patient Information:

Name: ____ SS Number: ____________________

Address:____ Date of birth____________________

City/State/Zip:____

Phone (Day):__________________Phone (Eve):__________________Email:____________________

Applicant/ Contact Person- if different from patient

Name:______________________________ Relationship to patient: ____________________

Address:____

City/State/Zip:____

Phone (Day):__________________Phone (Eve):__________________Email:____________________

I have been diagnosed with Leukemia (or am submitting this application on behalf of a minor who has been diagnosed with Leukemia) and require assistance with costs associated with my treatment. I hereby give permission to the staff of the Greater Salina Community Foundation to contact the parties listed in this application or attachments thereto for purposes of verification.

_________________ ____

Date Signature of Applicant

Please attach the following information to this cover sheet:

- A brief medical history, including condition of the patient with regard to Leukemia or the need for a bone marrow transplant.
- A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy.
- A statement from applicant's medical doctor attesting to the medical conditions and necessary treatment.
- A listing of expenses, real or projected, for which the grant is being requested.
- A timetable for the expenditure of the grant.

P.O. Box 2876
Salina, KS 67402-2876
785-823-1800

AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

PATIENT NAME	BIRTH DATE	SOCIAL SECURITY NO.
Patient Address		Patient telephone

CHECK ONE:

☐ I HEREBY AUTHORIZE PROVIDER TO USE PROTECTED HEALTH INFORMATION CONCERNINGTHE ABOVE-NAMED PATENT

X I HEREBY AUTHORIZE ALL OF MY HEALTH PROVIDERS, INCLUDING, BUT NOT LIMITED TO, ________________________________TO DISCLOSE PROTECTED HEALTH INFORMATION CONCERNING THE ABOVE-NAMED PATIENT TO: **The Greater Salina Community Foundation ("GSCF") its officers, directors, and grant-making committees for the purpose of determining the eligibility of the patient for grants administered by GSCF**

____

For Treatment date(s):____

Specify date(s)- this line MUST BE completed

For the following purposes(s) **At the request of patient and for all purposes connected with the above referenced grant request**

CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED (Unless the appropriate box is checked, Provider will not disclose records contained in its medical records prepared by health care providers not affiliated with Provider unless records were prepared on behalf of Provider)					
☐	Entire Record (will not include Billing Records or records not prepared by or on behalf of Provider unless those items also are selected) Records not prepared by or on behalf of Provider. Provider cannot be responsible for the completeness or accuracy of such records. Other____________________________	☐	Patient Demographic Information	☐	Cardiac Studies
		☐	Emergency Room Records	☐	Physician Progress Notes
		☐	Admission History & Physical	☐	Physician Orders
		☐	Consultation Reports	☐	Discharge Summary
		☐	Operative/Procedure Reports	☐	Nursing Notes
		☐	Lab Test Results	**X**	Billing Records or verification of financial need
		☐	Imaging/Radiology Reports	**X**	Physician letter to confirm diagnosis.

This authorization shall remain in effect **as long as the above-referenced grant request is pending and while I am receiving the grant** at which time this authorization to disclose the identified health information expires.

I understand that the records to be used or disclosed pursuant to this authorization may contain information is subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. § 65-5601 et seq., and K.S. A. § 65-6001et seq. I authorize Provider to use or disclose records containing such information if they are otherwise included within the scope of this authorization by checking the box(es) below:

☐ Records relating to participation in any federally assisted drug and alcohol abuse program

☐ Information relating to diagnosis and treatment of mental, alcoholic, drug dependency, or emotional condition

☐ Information relating to HIV testing, HIV status, or AIDS

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records as permitted by law. I understand that I may revoke this authorization at any time by providing a written notice to the designated privacy officer of the provider to whom this authorization is sent. (Note: Revocation is not effective for disclosures that have already been made)

_______________ ____

Date *Signature of Patient or Authorized Agent/Representative*

______________________________________ ______________________________________

Printed Name of Authorized Agent/Representative *Authorized Agent/Representative's Relationship to Patient*

______________________________________ ______________________________________

Address of Authorized Agent/Representative *Telephone # of Authoized Agent/Representative*

_______________ ____

Date *Signature of Witness*