Kingfisher Foundation

KINGFISHER PATIENT RELIEF PROGRAM

REQUEST FORM

TO BE COMPLETED BY A HOSPICE OR PALLIATIVE CARE REPRESENTATIVE ONLY

Patient Relief Request: *(Please check one)*

	Medication Cost		**Special Order for Medical Equipment**
	Medication Dispenser		**Complementary and Alternative Medicine**
	Medical Alert System		**Other:**
	Treatments (ex: Meditation, Art Therapy, Acupuncture, Energy Therapy, etc)		

Provider of Services/Resource:	
Anticipated Cost:	

Description of Need: *(Please include explanation of financial hardship and/or special circumstance of need.)*

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Patient Information:

Name of Patient:	
Address:	
Phone Number(s):	
Insurance Info:	
Diagnosis:	

Currently admitted to: *(Please check one)*

	HOSPICE CARE		**PALLIATIVE CARE**

By signing below, I attest, to the best of my knowledge, that all of the above information is true and complete. I understand that to be eligible for the Patient Relief Program, the recipient must be receiving hospice and palliative care services and have been diagnosed with a terminal or life threatening disease. I have discussed the request with my patient and have deemed it safe and reasonable if his/her request is granted.

_____

Hospice Representative Signature Date

The recipient of this donation agrees to indemnify and hold harmless Kingfisher Foundation and its staff from and against any and all loss, damages, liability, claims, suits, costs, and expenses resulting from the recipient's use of supplies or services.

_____

Recipients Signature Date

*****EMAIL THE COMPLETED REQUEST FORM TO KINGFISHER FOUNDATION (kingfisherfoundation@mail.com) OR PLACE IN DROP BOX AT OFFICE.**

Office Use Only:

Date:

Approval: Yes / No / Pending

Documentation Required: