Southern California Hospice Foundation

Angel Assistance Checklist:

Before submitting the application, please make sure you have the following items:

- ☐ Completed application with the patient's or DPOA's signature
- ☐ A brief letter detailing the request, estimated cost (if applicable), & how it would enhance the patient's quality of life
- ☐ A picture of the patient

Please have your hospice administrator sign below, acknowledge that they are aware and approve of this request.

Full Name of Administrator (please print) _____

Administrator's Signature: _____Date:_____

NOTES (Foundation Use Only):

Southern California Hospice Foundation

Dear Applicant:

At the Southern California Hospice Foundation, our mission is simple: To deliver a breadth of resources to caregivers, families and patients who are confronting the final stages of life. In supporting our mission, the Angel Assistance program helps to fulfill the needs of local area individuals facing a terminal illness.

Angel Assistance Criteria:

- Patient must currently be receiving hospice care
- Patient and Family must demonstrate financial need

If the applicant meets the criteria, please submit a compelling letter detailing the need of the request, including estimated costs, and how this request would enhance the patient's quality of life. A photo of the patient is also required to be submitted with the application.

We will NOT grant the following:

- Burial or cremation assistance
- Rent or mortgage
- Major home improvements

All applicants must be submitted by email or mailed to:

Michelle@SoCalHospiceFoundation.org
T: 877-661-0087 F: 714-557-4439
Southern California Hospice Foundation
3200 Park Center Dr. Ste. 1250
Costa Mesa, CA 92626

We will make our best efforts to assist with all eligible applicants as quickly and effectively as possible.

Kind Regards,

Southern California Hospice Foundation

Publicity Authorization

The Southern California Hospice Foundation (SCHF) and Angel Assistance Applicant hereby irrevocably authorize SCHF (a) to use the Applicant's name, likeness, image, voice, and/or appearance as such may be embodied in any pictures, photos, video recordings, audiotapes, digital images, and the like, taken, made on behalf of, or given to the SCHF for any publication, promotion, trade, business use, or any other purpose whatsoever; (b) to give SCHF full ownership to copyright, convey, or otherwise distribute, now and in the future, any such material involving the Applicant for any purpose to anyone, including but not limited to the general public, magazines, newspapers, radio stations, television, illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and the Internet or anyone else; (c) to publicize, now or in the future, the name of the Applicant including information regarding them, their physical or emotional conditions, and details of any request granted. The Applicant agrees that they will not receive any compensation, etc. for the use of such pictures, videos, etc., and hereby release the SCHF and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

The applicant has read and has understood this consent and release.

Full Name of Applicant (please print) _____

Signature of Applicant _____Date_____

Southern California Hospice Foundation

Applicant Information:

Patient Name:		Currently the patient lives:	at home ◯	in a facility/B&C ◯	
Address:					
City:		State:		Zipcode:	
Phone:		Email:		Annual Family Income:	
Date of Birth:		Gender:		Terminal Diagnoses:	
Patient a Veteran?	Yes ◯ No ◯	Ethnicity:		Language Preference:	

Caregiver Information:

Name of Primary Caregiver:					
Relationship to Patient:		Phone:		Email:	
Address:					
City:		State:		Zipcode:	

Hospice Representative Information:

Hospice Representative Name & Title:		Hospice Provider:			
Address:					
City:		State:		Zipcode:	
Phone:		Fax:		Email:	

Liability and HIPPA Release:

I acknowledge that no promises or assurances have been made to me by the Southern California Hospice Foundation (SCHF) regarding my Angel Assistance request. I understand that SCHF reserves the right to decide if a request will be granted or terminated at any time. I declare that I have complied with all conditions, qualifications, and restrictions imposed by SCHF. I agree that I will execute and deliver to SCHF all further documents that SCHF deems necessary or appropriate in order to prepare, execute and fulfill the Angel Assistance request.

I authorize and request the herein mentioned medical professional to release to SCHF all information required by SCHF in relation to the health of the Applicant. A photocopy of this authorization shall be valid as the original.

I hold harmless SCHF, its officers, directors, volunteers and employees from any and all losses suffered as a result of any claim, lawsuit or action rising out of or relating in any manner to SCHF's preparation, execution and fulfillment of the Angel Assistance Request. I have read and understood the Liability Release as outlined above, and I consent to the collection and disclosure of personal information in accordance with the Liability Release. Where I have provided information about another individual, I declare that the individual has been made aware of the facts and content of the Liability Release.

Applicant's Signature:		Date:	
Hospice Represenative's Siganture:		Date:	

Southern California Hospice Foundation

A brief letter detailing the request, estimated cost (if applicable), & how it would enhance the patient's quality of life: