



Southern California Hospice Foundation

We Honor Vets Request Form

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 expanding our reach and support for our community members, we believe in collaborative efforts to help elevate the way we live. It is our pleasure to support events that align with the mission of our organization.

Please be sure to complete this form and submit it, along with an invoice or itemized list, to SCHF Program Manager: Arnie Lynn Bengo at arnie@socalhospicefoundation.org

Applicant Information:

Patient name: _____ DOB: _____ Gender: _____

Patient Housing (please circle): Home ALF SNF B&C

Address: _____

City: _____ State: _____ Zip: _____

Terminal Diagnosis: _____

Hospice Representative/Requestor Information:

Hospice Representative Name& Title: _____

Hospice Provider: _____ City and State: _____

Phone: _____ Email: _____

Detailed Description of Request:



Southern California Hospice Foundation

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.

Requestor's Initials: _____

Patient's Initials: _____

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 Patient (please print): _____

Signature of Patient: _____

Signature of Hospice Representative/ Requestor: _____

Date: _____