

# Wish Fund Grant Request Application

The Wish Fund was established to create special memories for people with a dire health diagnosis or terminal illness that limits life expectancy and who are living in Clinton, Essex or Franklin Counties in New York. This fund was created through a donation by the Adirondack Champlain Valley Realtors (“ACVR”) to The Foundation of CVPH (“Foundation”). Together, the Foundation and ACVR do our very best to grant wishes for those unable to create them on their own. We will review each request as quickly as possible.

## Here's how it works:

- Fill out sections 1-5 of this application and execute the application in section 6;
- We review the application to determine your (or your dependent's) eligibility based on numerous factors;
- We approve or deny your application upon being received;
- If approved, we provide grants up to a value of \$5,000;
- **Completed applications should be turned into The Foundation of CVPH, 75 Beekman Street, Plattsburgh, NY 12901.**

## Previous wishes have included:

• Family trip to Walt Disney World	• A special family dinner
• Car trip to Dollywood	• A pig roast with family and friends
• Visit to the Bronx Zoo	• Driving vacation around Maine in the summer
• Tickets to the Boston Bruins	

## There are a few types of wishes we cannot provide grants for:

- Cruises
- Cash
- Surprise wishes
- Reimbursements for completed wishes
- Funeral arrangements, posthumous requests, legal assistance or personal bills
- Flights outside the United States. However, on a case-by-case basis we may consider one-way travel to countries outside of the U.S. for patients who wish to die at home and on a case-by-case basis we may consider travel to U.S. territories
- Any wish request deemed offensive, inappropriate or inconsistent with the values of the ACVR and The Foundation of CVPH
- Foundation may deny wishes that it determines pose a risk to participants based on the nature of the activity and the health status of the participant.
- Medical treatment, supplies, equipment and transportation as well as property and home improvements/repairs will be considered on an individual basis.

## **Step 1 – Documentation Requirements:**

Please include a photograph and personal letter (outlined in detail below).

- Photograph: Must be clear and taken within the past year. It may include family, pet, etc.
- Letter: Your letter should be no longer than one page in length, one side, and refer to the illness you are battling.
- Clearly describe your wish and where the most help is needed to fulfill it.

## **Step 2 -General Information:**

Applicant's Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Clubs, Organizations or Churches you are a member of (Optional): \_\_\_\_\_

Present/Most Recent Employer: \_\_\_\_\_

Other Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

(Including City/State/Zip if different from above)

## **Step 3 – Request:**

Please describe your request:

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## Step 4 -Medical Information:

### **This Part To Be Completed By Physician Only**

HIPAA Compliant Authorization Provided: [  ] yes or [  ] no

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
(Including City/State/Zip)

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Fax Number: (\_\_\_\_\_) \_\_\_\_\_

If patient is under hospice care - Hospice Name: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_

Applicant's Diagnosis: \_\_\_\_\_

**Current Life Expectancy in MONTHS:** \_\_\_\_\_

I certify that I am the treating physician of the Applicant. To the best of my knowledge, my patient **has a life expectancy of twenty-four (24) months or less** OR my patient could not actively participate in the requested wish beyond the next twelve months. I certify that my patient is of sound mind, and capable to sign legal documents. I have discussed (or will discuss) the wish request with my patient and have deemed it safe and reasonable if his/her wish is granted within the next three months.

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Signature of Physician, NP or PA only

Title

Date

## Step 5 –LEGAL TERMS

**Please initial items 2, 3, 4, 5 and 20 (Option 1 or 2) where indicated, below:**

1. **Granting of Wish.** The Foundation and ACVR reserves the right in its/their sole and absolute discretion, to approve or deny the application of the Applicant (as identified below) for item or experience the applicant has described in the letter annexed to this Application ("Wish").

2. **Permission to disclose medical condition.** The Applicant or Applicant's authorized representative has signed a HIPAA compliant authorization allowing the Foundation and the ACVR to receive the Applicant's medical information.

3. **Waiver.** The Applicant and all Participants (as identified below) hereby waive any and all rights he or she may have or may hereafter acquire against Foundation, its officers, directors, agents, and employees arising out of any injury, damages, or losses suffered by the Applicant, and all participants, arising out of or in any way related to Foundation preparation, execution or fulfillment of the Wish, regardless of whether such loss or harm is caused by the active, passive or gross negligence of Foundation or any other person. \_\_\_\_\_ [initial here]

4. **Release.** Applicant, and all Participants, together, and each of them individually, does hereby forever release and remise Foundation, its officers, directors, agents, and employees from any and all claims, lawsuits, damages, or losses arising out of or in any way related to Foundation preparation, execution or fulfillment of the Wish, any injury, damages, or losses suffered by Applicant or Participants, or any of them of whatever nature, and of whatever extent, regardless of whether such loss or damage is caused by the active, passive or gross negligence of Foundation or any other person. \_\_\_\_\_ [initial here]

5. **Indemnity.** Applicant, and all Participants, together and each of them individually, hereby agree to indemnify and hold harmless Foundation, its officers, directors, agents, and employees of and from any and all losses suffered by Foundation, its officers, directors, agents, and employees as the result of any claim, lawsuit, or action arising out of or relating in any manner to Foundation's preparation, execution and fulfillment of the Wish, or due to a breach by Applicant, or any Participants, of the representations, warranties or covenants contained in this agreement. Said hold harmless and indemnity includes, but is not limited to, reasonable attorneys fees and costs incurred by Foundation, its officers, directors, agents, and employees in retaining attorneys of Foundation's choice to defend any and all such claims, lawsuits, and actions. \_\_\_\_\_ [initial here]

6. **Relatives/Friends.** Persons may accompany the Applicant during any portion of the Wish fulfillment, if specifically agreed to in writing between Foundation and Applicant and identified as a Participant herein.

7. **Wish expenses.** The expenses Foundation has agreed to pay for are those foreseeable and directly related to the fulfillment of the Wish. Applicant and Participants together understand that they may be forced to incur substantial expenses as a result of unforeseen events or circumstances beyond Foundation's control, especially if fulfillment of the Wish involves travel. Foundation shall not have any responsibility or liability for expenses incurred by Applicant, relatives or friends which have not been expressly agreed to by Foundation pursuant to this Agreement, which have been caused by unforeseen events, or circumstances beyond Foundation's control. For example, a particular Wish may contemplate Foundation paying for certain specific expenses for a specific period of time while Applicant is traveling away from home. If Applicant's medical condition deteriorates so that immediate hospitalization is necessary, Applicant may be forced to remain away from home longer than the period of time contemplated by the wish. In that event, it will be the sole responsibility of the Applicant, or his or her authorized representative, to pay for all expenses in excess of those for which Foundation has agreed to pay, whether medically-related, for meals and lodgings, including hospitalization, or for other goods, or services of any nature. **If death occurs during wish, Foundation is unable to assist in any way.**

8. **Fundraising.** ACVR may undertake a campaign, with the Applicant's prior approval, to raise funds and/or Frequent Flyer Miles to fulfill the Wish. Money raised specifically for you will be used for the Applicant's Wish. Funds or Miles raised generally may be utilized for other applicants.

9. **Representations and warranties.** Applicant makes the following representations and warranties to Foundation:

- (a) Applicant has made a true and full disclosure of all medical conditions to Foundation;
- (b) All information contained in the application and any materials provided in support of the Application are true and correct in all material respects;

(c) Applicant will notify Foundation if and when Applicant's medical condition should deteriorate at any time prior to fulfillment of the Wish;

(d) Applicant and Participants are carrying, full medical insurance, including any additional coverage which may be required as a result of the Wish to be fulfilled. Applicant and Participants assume the risk and personal responsibility of failing to carry adequate medical insurance;

(e) **If fulfillment of the Wish involves travel, they are able to bear the financial burden of the potentially substantial expenses which they may be forced to personally incur as a result of unforeseen circumstances or events beyond Foundation's reasonable control (as set forth in paragraph 7), and that they assume the risk and personal responsibility for such expenses;**

(f) Applicant has not previously been granted a Wish by Foundation or another charitable wish granting organization; and

(g) In requesting Foundation to fulfill the Wish, Applicant is not relying upon nor have they received any counsel or advice from Foundation with respect to the advisability of or the risks attendant to the Wish.

**10. Termination of Relationship.** Foundation shall terminate the preparation and/or fulfillment of the Wish if: (1) the Foundation determines, after consulting with a medical professional, that fulfillment of the Wish may endanger the health or safety of Applicant or of others involved in the Wish; (2) Foundation determines, after consulting with a medical professional, that the Applicant is or will be incapable of appreciating or utilizing the Wish; (3) the Applicant passes away prior to the fulfillment of the Wish; or (4) Foundation determines, in its sole and absolute discretion, that Applicant, his or her wish or the Participants do not represent the values of the Foundation or those of its corporate partners; or (5) Applicant and any Participants have breached any of the representations, warranties or covenants contained in this Agreement. In the event Foundation terminates preparation or fulfillment of the Wish, Applicant, and all Participants agree that Foundation shall not be held liable or responsible for any expenses that Applicant, or any Participants, may have incurred in contemplation of Foundation's fulfilling the Wish. NOTE: Only Foundation may make a request for resources on behalf of a Wish. If the Applicant, or any Participants, friends or anyone having knowledge of this Wish uses the name of Foundation to solicit support, the Wish will be immediately disqualified and terminated.

**11. Further Assurances.** Applicant and all participants agree that he or she shall, at the request of Foundation, execute and deliver to Foundation all further documents that Foundation deems necessary or appropriate in order to prepare, execute and fulfill the Wish, including without limitation, evidence of permission to perform a background check on the Applicant.

**12. Counterparts.** This Agreement may be executed in counterparts, any of which shall be deemed to be an original.

**13. Amendment.** This Agreement shall not be modified or superseded, except by a writing executed by the parties.

**14. Governing law.** The laws of the state of New York shall govern this Agreement without regard to its conflict of laws principles.

**15. Binding effect.** This Agreement is binding on all heirs, successors, representatives, and assigns of all parties hereto.

**16. Severability.** If any portion of this Agreement shall be determined to be invalid or unenforceable, all other portions shall remain valid and enforceable.

**17. Entire agreement.** This Agreement, the application and all materials provided in support of the application constitutes the entire Agreement and understanding of the parties with respect to the transaction contemplated hereby, and supersedes all prior agreements, arrangements and understandings related to the subject matter. No representation, promise, inducement or statement of intention has been made by any of the parties hereto not embodied in this Agreement and no party shall be bound by or liable for any alleged representation, promise, inducement or statements of intention not set forth or referred to herein.

**18. Captions.** The Captions appearing in this Agreement are for convenience and ease of reference only. They in no way describe, limit or extend this Agreement or any of its provisions.

**19. Grant of Right of Publicity.** PARTICIPANT and Applicant UNDERSTAND AND AGREE THAT FULFILLMENT OF THE WISHMAY RESULT IN PUBLICITY, WHETHER OR NOT THE Foundation ACTIVELY TAKES STEPS TO PUBLICIZE THE WISH. The Applicant and Participants hereby irrevocably authorize Foundation: (a) to publicize and use Applicant's and/or Participant's likenesses, voices and features, with or without their names, for any publication, promotion, advertisement, trade, business use, or any other purpose whatsoever in

perpetuity; (b) to photograph, videotape, film, and record each Applicant and/or Participant in any manner the Foundation chooses; (c) to copyright, convey, transmit or otherwise distribute, now or in the future, any such material involving the participants for any purpose to anyone, including the general public, through all media presently in existence or later invented, throughout the world, including without limitation print, video, television, radio, digital, internet, and social media; (d) to publicize, now or in the future, the names of the Applicant or Participants including information regarding them, their physical or emotional conditions and the details of any Wish granted. The Applicant and each of the Participants agree that it is not necessary for Foundation or anyone else to contact them prior to releasing any information authorized by this document. Each of the Participants hereby releases Foundation from all liability, damages, or claims of any kind resulting in or from, or arising from the use, distribution or disclosure of any photographs, films, videotapes, electronic recording or other information regarding Participants and the Wish.

Initial here: \_\_\_\_\_ (Must be initialed by ALL Participants)

## Step 6 –Signatures

**By signing below, you affirm and acknowledge that you have read this Application, have retained a copy, and fully understand and agree to its provisions, including the Legal Terms in Section 5. All Participants must sign below. For any minor Applicant or Participants, the signature of their parent or guardian is both on behalf of the parent or guardian and on behalf of the minor.**

Signature of Applicant	Authorized Representative of Applicant
Date:	Relationship of Authorized Representative to Applicant
Signature of Participant	Date:
Signature of Participant	Date:

**HIPAA FORM**  
Authorization for Use/Disclosure of Protected Health Information

TO: \_\_\_\_\_  
(Physician)

\_\_\_\_\_  
(Physician's Address)

\_\_\_\_\_  
(Physician's Telephone Number)

RE: \_\_\_\_\_  
(Patient – Print Name Legibly)

\_\_\_\_\_  
(Patient's Date of Birth)

I authorize Champlain Valley Physicians Hospital Medical Center to use and disclosure to The Foundation of CVPN of protected health information about Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessments of:

- (a) whether Patient is medically eligible for Foundation services; and
- (b) if so, whether his/her desired wish is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to the Foundation forms that the Foundation may require, including forms relating to Patient's medical eligibility, the requested wish and medical considerations relating thereto.

Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives.

Persons authorized to receive the information: Employees or other authorized representatives of: The Foundation of CVPN, 75 Beekman Street, Plattsburgh, NY 12901, (518) 562-7169, UVMHealth.org/CVPN

Purpose for which information will be used/disclosed: To enable Foundation to obtain:

- (a) physician's assessments regarding whether Patient is medically eligible to have a wish granted by the Foundation and, if so, whether the requested wish is medically appropriate; and
- (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's wish has been granted by Foundation or a final determination has been made that Patient is not eligible to receive a wish.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

- (a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization;
- (b) I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient Name

Patient Signature

Date

Patient Representative

Patient Representative Signature

Date