waves of grace

ARE YOU OR SOMEONE YOU KNOW INTERESTED IN OUR PROGRAM? ONLY ONCOLOGY TEAM MEMBERS ARE PERMITTED TO MAKE A NOMINATION TO OUR PRO-GRAM. PLEASE CONTACT US USING THE APPROPRIATE FORM BELOW.

IN ORDER TO ENSURE AN EFFICIENT PROCESS, PLEASE REVIEW SOME OF OUR GUIDELINES TO ENSURE ELIGIBILITY FOR OUR RESPITE BEACH VACATION PROGRAM. NOMINEES LIVING IN THE SOUTHEAST REGION OF THE UNITED STATES WILL RECEIVE FIRST PRIORITY SIMPLY DUE TO TRAVEL EXPENSES. WE ARE A SMALL 501C3 NONPROFIT AND ARE TRYING OUR BEST TO HELP AS MANY PEOPLE AS POSSIBLE WHILE MAINTAINING THE INTEGRITY OF OUR MISSION.

INSTRUCTIONS TO NOMINATOR:

Waves of Grace nominees must meet all the eligibility requirements listed below. Please submit the referral form by scanned via **email to rest@waves-of-grace.org** or **mail to: 1217 Chickasaw Dr. Brentwood, TN 37027**

ELIGIBILITY REQUIREMENTS: ALL NOMINEES MUST:

1. Have stage 3 or later stage limited life expectancy cancer;
2. Have a life expectancy of three (3) or more months;
3. Be referred by the treating oncologist.

4. Nominees must not have previously participated in a dream, wish or any other similar program within a year of nomination to Waves of Grace.

5. Minimum age to receive a Waves of Grace respite beach vacation is age 2.

INSTRUCTIONS:

Please PRINT. To be eligible, all forms must be fully completed, including all required signatures. All participants must sign the Participant Consent Form. Parents must sign for minor children.

Nominees will be contacted after all forms, has been received. Please print neatly to ensure everything is read accurately. Please email or mail completed nomination to:

Email: rest@waves-of-grace.org

Mail: 1217 Chickasaw Dr. Brentwood, TN 37027

Should you have any questions, please do not hesitate to contact the Waves of Grace

Jennifer Matwijec, Director (615)364-4947

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NOMINEE INFORMATION FORM

Instructions: Please input information regarding Nominee family.
Nominee/Patient Information: (As listed on your driver's License)

NAME: ____________________ ____________________ ____________________
Last Name First Name Middle Name

BIRTH DATE: ____/____/_____ **SS#:** _______ - _____ - ___________

SPOUSE'S NAME: ________________ ________________ ______________
Last Name First Name Middle Name

BIRTH DATE: ____/____/_____ **SPOUSE'S CELL:**____________________

NOMINEE'S ADDRESS: ____

CITY: _______________ **STATE:** __________ **ZIP CODE:** _______________

HOME PHONE: __________________ **CELL PHONE:** __________________

EMAIL: __________________________

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Names of Children or family members/caregivers vacationing with the nominee, date of birth: (Please note we only cover the travel expenses of the nominee and family members/caregivers in the household of the nominee. Other family/loved ones are welcome to go on the vacation as long as the number of occupants doesn't exeed the maximum capacity of the beach property.)

Patient's Occupation:

Patient's Employer:

Spouse's Occupation:

Spouse's Employer:

TO:

PHYSICIAN: ____

PHYSICIAN'S ADDRESS: ____________________________________

CITY: ______________ **STATE:** __________ **ZIP CODE:** _______________

HOME PHONE: _________________ **CELL PHONE:** _________________

RE:

PATIENT: _________________________ **Patient's Date of Birth:** ___ / ____ / ____

Print Name Legibly

HIPAA RELEASE FORM

I authorize the use and disclosure to Waves of Grace 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 Waves of Grace services; and (b) if so, whether his/her desired respite beach vacation is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to Waves of Grace forms that Waves of Grace may require, including forms relating to Patient's medical eligibility, the requested beach vacation and medical consideration 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 Waves of Grace.

Purpose for which information will be used/disclosed: To enable Waves of Grace to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a respite beach vacation granted by Waves of Grace and, if so, whether the requested vacation is medically appropriate; and (b) pertinent information relating thereto.

Expiration date/event: This authorization expires once Patient's respite beach vacation has been granted by Waves of Grace or a final determination has been made that Patient is not eligible to receive a respite beach vacation.

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 regulation, 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:** ________________

Waves of Grace

NOMINEE'S STATEMENT

I hereby warrant and represent that the information provided to Waves of Grace is accurate. I consent to be contacted by Waves of Grace via phone or e-mail at the numbers/addresses provided by me or my Referral Agent in regard to a Waves of Grace respite beach vacation.

NOMINEE SIGNATURE: ______________________________

PRINT NAME: ______________________________ **DATE:** ______________________________

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ONCOLOGY NOMINATOR INFORMATION FORM

Instructions: The nominating oncology staff person ("Nominator") should complete this form to provide Waves of Grace the necessary contact information.

CONTACT INFORMATION: (Person at oncology office we call, should we need additional information.)

NAME:

NAME OF HOSPITAL/CANCER/ONCOLOGY CENTER/ORGANIZATION:

ADDRESS:

PHONE: **E-MAIL ADDRESS:**

MEDICAL INFORMATION FORM

Instructions: This form is to be completed by the patient's treating physician.

PHYSICIAN'S NAME:

HOSPITAL/CENTER/ORGANIZATION AFFILIATION:

PATIENT'S NAME:

DIAGNOSIS:

1. Time Frame of respite beach vacation: Please list the dates of preferred travel weeks. We will try our best to accommodate the best week (7 days or less) for your family.

2. Travel limitations/special needs please list below:

PHYSICIAN'S STATEMENT

I hereby acknowledge that the Medical Information above has been completed to the best of my knowledge and hereby permit ____________ ("Nominee") to participate in the respite beach vacation offered by Waves of Grace and acknowledge that the Nominee may participate despite the medical limitations listed above.

Physician's Signature: __________________ Date: ____________

Physician's Contact Information

E-mail Address:________________________ Phone:___________