Are you or someone you know interested in our program? Only Oncology Team members are permitted to submit the application to our program. In order to ensure an efficient process, please review some of our guidelines to ensure eligibility for our **Disney respite vacation** program. Applicants stage 3+ and living in the southeast region of the United States will receive first priority simply due to property locations and 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 the applicant:

Waves of Grace applicants must meet all the eligibility requirements listed below. Please submit the referral form by scan via email or address provided below.

### Eligibility Requirements:

#### All applicants 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. Applicants must not have previously participated in a dream, wish or any other similar program within a year of application to Waves of Grace.
5. Minimum age to receive a Waves of Grace Disney respite 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. Applicants will be contacted after all forms have been received. Please print neatly to ensure everything is read accurately. Please email or mail completed application 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 Waves of Grace
Jennifer Matwijec, Director (615) 364-4947

## Application Form

Applicant/Patient Information (as listed on your driver's license)

NAME:

_____

LAST FIRST MI

BIRTH DATE: _____ /_____ /_____ SS#: _____ - _____ - _____

APPLICANT'S ADDRESS:

_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL: _____

PATIENT'S OCCUPATION: _____

PATIENT'S EMPLOYER: _____

Please list the names of Children or family members/caregivers vacationing with the applicant and their date of birth: Please note, we only cover the travel expenses of the applicant and family members/ caregivers in the household of the applicant. Other family/loved ones are welcome to go on the vacation as long as the number of occupants does not exceed the maximum capacity of the property.

Time Frame of Disney respite 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.

Travel limitations/special needs please list below:

## Medical team contact

PHYSICIAN/ONCOLOGY TEAM MEMBER:

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HOSPITAL/TREATMENT CENTER ADDRESS:

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CITY: _____ STATE: _____ ZIP CODE: _____

PHONE: _____

EMAIL: _____

RE.
PATIENT:

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Patient's Date of Birth: _____ / _____ / _____


## 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 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, 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 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 vacation has been granted by Waves of Grace or a final determination has been made that Patient is not eligible to receive a respite 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

## Applicant'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 oncology team in regard to a Waves of Grace respite vacation. If granted a respite vacation, I will be traveling at my own risk. If selected a recipient of Waves of Grace, I recognize the travel risk and acknowledge that there are certain risks of physical injury, including death, damages, property damage, or loss which I may sustain as a result of traveling to and from as well as during my stay at a property. I agree to waive and relinquish all claims that I may have for injuries or damages, as a result of participating in a respite vacation through Waves of Grace and its officers, agents, servants, employees, other volunteers, and affiliates as well as the property owners.

APPLICANT SIGNATURE:

_____

DATE

PRINT NAME:

_____

## Photo release:

I give Waves of Grace and professional photographer used for the free photo session permission to use my photographs on social media, website, and marketing.

YES: ____

NO: ____

Applicant's Signature:

_____

DATE

## To Be Filled Out By Physician/Oncology Team Only:

**Instructions:**
The physician or oncology team member should complete this form to provide Waves of Grace the necessary contact and diagnosis/eligibility information.

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

NAME:

_____

NAME OF HOSPITAL/CANCER/ONCOLOGY CENTER/ORGANIZATION:

_____

ADDRESS:

_____

PHONE: _____ E-MAIL ADDRESS: _____

## To Be Filled Out By Physician/Oncology Team Only:

**Instructions:**
The physician or oncology team member should complete this form to provide Waves of Grace the necessary contact and diagnosis/eligibility information.

### Medical Information:

PATIENT'S NAME:

_____

DIAGNOSIS/STAGE:

_____

### Physician's Statement:

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

Physician's Signature:

_____

DATE

E-mail Address: _____

Phone: _____