KATHI'S CAREGIVERS APPLICATION

Eligibility Requirements

1. Candidate must be a full or part-time family caregiver.

2. Income of candidates must not be more than $60,000 per year for singles/couples and $80,000 a year for families.

3. Applicant must be physically and mentally able to care for his or her personal and financial needs. Applicant must plan for emergency and other care for his or her patient and property in case of accident, illness or death.

4. Applicant must complete application for assistance.

5. We request a picture of the caregiver and patient, which may be used with Kathi Koll Foundation communications including a blog and social media. This is not required but appreciated.

General Information for KKF Assistance

1. Assistance ranges from $500.00 to $1,500.00 per candidate.

2. Assistance will be provided directly to the provider of services (i.e. utility bill, wheelchair, temporary caregiver service, etc.) or a merchant gift card given directly to the candidate.

Copies of the following documents and information are required:

1. Completed application (below). Incomplete applications will be returned.

2. 1-2 reference(s) (including one medical reference such as a doctor or nurse.)

3. Signed HIPPA Compliance Waiver

PLEASE BE SURE THAT ALL REQUIRED DOCUMENTS ARE INCLUDED WITH YOUR APPLICATION AND EMAIL TO colleen@kathikollfoundation.org.

KATHI'S CAREGIVERS APPLICATION

Caregiver Name: ____

Patient Name: ____

Address: ____

Telephone ______________________ Alternate Number ____________________

Email Address: ____

Caregiver Date of Birth ____

Patient Date of Birth ____

Length of time serving as a family caregiver ______________________________

Income Sources:
Amount $

_______________ Employment
_______________ Social Security
_______________ Service Connected Disability
_______________ Pension
_______________ Child Support
_______________ Other Income ______________________ Source
_______________ Other Income ______________________ Source

My total gross income is $____________

My total assets, not including one automobile, are approximately $________________

Monthly expenses: (Utilities, telephone, cable, rent, food, insurance, medication, etc,)
a.____ $____________
b.____ $____________
c.____ $____________
d.____ $____________
e.____ $____________
f.____ $____________

I heard about The Kathi Koll Foundation or was referred by: ______________________________
____

THE Kathi Koll FOUNDATION
Supporting Caregivers in Need

KATHI'S CAREGIVERS APPLICATION

Please answer the following questions:

1. Why are you applying for assistance?

2. Are you a full or part-time caregiver? Who are you caregiving for?

3. Are you employed full or part-time? If so, please tell us what you do and describe any current challenges.

4. How long have you been a caregiver? Please describe the events that led you to becoming a caregiver and the current challenges you are experiencing.

5. As mentioned above the Foundation cannot provide cash directly to candidates. Given this, please tell us what type of support would relieve your greatest burden and be the most meaningful to you?

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I, ________________________, understand that my application will not be considered complete until all verification documents on page 1 are submitted. I understand that once my application is submitted, I will be contacted by a Program Representative for an interview and that the process can take up to 30-60 days.

I understand that failure to provide accurate information or a material misstatement in this APPLICATION will be enough reason to deny financial assistance from the KKF.

I grant the Kathi Koll Foundation the unrestricted right and permission (but not the obligation) to reproduce,exhibit, publish, broadcast, and otherwise exploit any photographs or pictures I provide (the "Photos"), in whole or in any manner, on the KKF Foundation website, on social media, and through any other markets and media, without compensation to me or any other person. I confirm that I have the right to grant that permission, including the consent and agreement of the photographer and any other person in the Photos.

I declare under penalty of perjury that the foregoing is true and correct and that I have executed this APPLICATION on ______________ 20____.

____
Signature of Applicant

____
Witness Printed Name

____
Witness Signature

PLEASE EMAIL THIS COMPLETED FORM AND ACCOMPANYING DOCUMENTS TO:
colleen@kathikollfoundation.org

HIPPA Compliance Waiver

Under the HIPAA privacy regulations, individuals have a number of rights relating to their personal health information (PHI) used or maintained by an employee or business associate within our company.

Although as a non-profit we are not subject to all of the HIPAA privacy and security regulations; we are subject to some of the privacy rules relating to the PHI of our charity caregiver recipients that received our volunteer services.

Unless permitted in writing by the recipient, the recipients' PHI, including personal information such as diagnosis, nature of services, treatment, and provider records cannot be released to the outside general public or even to the recipient unless there is a signed consent by the recipient. However, we may use general statistical data on all of our recipients such as some patient demographic data, health insurance status, dates of patient services, general type of department in which a patient is serviced, treating physician information, and outcome information for the purpose of fundraising and marketing events. Any data sent electronically about our recipients is also safeguarded by the company, and this information is limited to employees and management that have received HIPAA training. If a breach of information occurs we will notify the recipient by phone and in writing and immediately move to correct the breach. There are a few exceptions mandated by the government under the following HPAA rules:

1. PHI may be used or disclosed for the treatment, payment and health care operations of any healthcare provider having a relationship with the recipient. We may also share information as it directly relates to being able to provide financial support for your situation (ex: sharing your spouse's condition with the home health aide company for whom we would pay to provide help to your spouse). With the consent of the recipient, the company may use and release PHI such as their name, general condition, religious affiliation, and location of the provider's facility to those individual entities involved in the recipient's care and with the recipient's permission for the purposes of notifying family members and others, regarding an individual's location condition or death. An example would be a pharmacist dispensing a filled prescription to a person acting on behalf of the patient.

2. PHI may be disclosed when the recipient is incapacitated or in an emergency situation when the disclosure is in the best interest of the recipient.

I have read and understand this document and agree with how my PHI may be disclosed by The Kathi Koll Foundation:

Recipient's name: ____

(PLEASE PRINT)

Signature: ____ *Date:* ____________