Coastal Family Vacation Foundation, Inc.

A South Carolina Nonprofit 501(c)3

Established 2021

NOMINATION PACKAGE

Coastal Family Vacation Foundation, Inc. (CFVF) will award a limited number of respite packages each year through the CFVF Cancer Respite Program as funding permits.

Please submit the nomination package only after all sections are complete and have been signed.

NOMINEES MUST MEET ALL OF THE FOLLOWING ELIGIBILITY REQUIREMENTS:

1. A South Carolina resident at time of nomination.

2. Actively being treated for potentially limited life expectancy cancer.

3. Nominated and recommended for a vacation by their **treating oncologist**.

4. Have a life expectancy of at least 3 months.

5. Have not previously accepted a scholarship, prize, wish, dream or any other similar program related to their illness.

6. Willing to sign a waiver releasing CFVF and its partners and affiliates from all liability associated with the award and acceptance of a respite vacation.

7. **Able and willing to take respite within 6 months** of submitting the Nomination Package. (To allow CFVF to serve as many families as possible, priority is given to families willing and able to vacation soon after their application date. The program is designed to offer families a respite during treatments.)

INSTRUCTIONS:

1. Complete all forms in legible print and obtain all required signatures. Parents must sign for minor children.

2. Email completed package and a copy of SC driver's license to: admin@coastalfamilyvacation.org

3. If you have questions, please email us at admin@coastalfamilyvacation.org or call Kaitlan Keller at 803-464-4516.

Incomplete packages cannot be considered.

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NOMINEE INFORMATION FORM

Nominee/Patient Information: (As listed on your South Carolina Driver's License)

NAME: _____ _____ _____
(Last Name) (First Name) (Middle Name)

BIRTH DATE: _____ /_____ /_____ Last 4 of SS#: ***-**-_____

PHYSICAL ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ MOBILE PHONE: _____

EMAIL: _____

OCCUPATION: _____

EMPLOYER: _____

TYPE OF CANCER BEING TREATED: _____

_____

SPOUSE NAME: _____ _____ _____
(Last Name) (First Name) (Middle Name)

BIRTH DATE: _____ /_____ /_____ MOBILE: _____

OCCUPATION: _____

EMPLOYER: _____

How Did You Hear About CFVF: _____

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NOMINEE INFORMATION FORM (con't.)

CFVF secures accommodation and provides a grocery and travel stipend to offset expenses for the nominee and family members/caregivers **living in the household** with the nominee. Other family/loved ones may join the nominee on the vacation, at their own expense, as long as the number of occupants does not exceed the maximum capacity as defined by the property owner.

List all family members/caregivers living in the household who plan to vacation with the nominee. Rental agencies require this information for all guests staying on the property.

Name of Household Member (not Patient):	Relationship to Patient:	Birthdate:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Guest **if** Space in House Allows:	Relationship to Patient:	Birthdate:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Travel Dates: Please list the preferred vacation timeframe **within 6 months** of date of application. The CFVF Cancer Respite Program provides accommodation for up to 7 nights. We will try our best to accommodate your preferred dates.

Month/Season/Dates: _____

_____

PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

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

HIPAA RELEASE FORM

I hereby authorize the use and disclosure of my protected health information to Coastal Family Vacation Foundation, Inc. (hereafter CFVF) as described below:

1. Information that may be used/disclosed: All protected health information relating to Physician's assessments of: (a) whether above Patient is medically eligible for CFVF services within the criteria described on page 1 of the Nomination Package; and (b) if so, whether Patient's desired family beach respite vacation is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to CFVF forms that CFVF may require, including forms relating to Patient's medical eligibility, the requested beach vacation and medical consideration relating thereto. 2. Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives. 3. Persons authorized to receive the information: Directors or other authorized representatives of CFVF. 4. Purpose for which information will be used/disclosed: The purpose of this disclosure is to enable CFVF to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a family beach respite vacation granted by CFVF and, if so, whether the requested vacation is medically appropriate; and (b) pertinent information relating thereto. 5. Expiration date/event: This authorization expires once Patient's family beach vacation has been granted by CFVF or a final determination has been made that Patient is not eligible to receive an award of a beach vacation. 6. 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 or Representative's Signature: _____

Patient Name: _____ Date: _____

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NOMINEE INFORMATION FORM (con't.)

NOMINEE CERTIFICATION:

Initial all Statements indicating agreement and/or acceptance:

_____ I hereby certify and attest that the attached information being provided to Coastal Family Vacation Foundation, Inc. is true, accurate, and complete.

_____ I consent to being contacted by representatives of Coastal Family Vacation Foundation, Inc. via phone or e-mail at the numbers/addresses provided herein as relates to participating in the CFVF Cancer Respite Program.

_____ I hereby confirm that I am a legal resident of the state of South Carolina and have attached a copy of my SC driver's license.

_____ I hereby confirm that I have not previously received another a scholarship, prize, wish, dream, or any other similar program in relation to my illness within the past 2 years.

_____ If selected to participate in the CFVF Cancer Respite Program, I understand and agree that I will sign an agreement waiving all liability / hold harmless agreement releasing CFVF and its partners and affiliates from all liability associated with the Program.

_____ If selected to participate in the CFVF Cancer Respite Program, I understand that I will be responsible for any income taxes that arise from acceptance of said respite vacation.

_____ If selected to participate in the CFVF Cancer Respite Program, I agree to complete and return the CFVF Performance Measurement Survey within 2 weeks of taking respite.

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 Coastal Family Vacation Foundation, Inc. the necessary contact information. CFVF will contact the Nominator to confirm the accuracy of the information as submitted.

CONTACT INFORMATION: Name of the person at the oncology office nominating the patient for the vacation. This is the person CFVF will contact to verify information such as diagnosis and treatment schedules.

NAME: _____

JOB TITLE: _____

NAME OF HOSPITAL/CANCER/ONCOLOGY CENTER/ORGANIZATION:

_____

ADDRESS: _____

PHONE: _____

TREATING ONCOLOGIST: _____

E-MAIL ADDRESS: _____

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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 AND TREATMENT PLAN: _____

_____

_____

_____

ANY TRAVEL LIMITATIONS, REQUIRED EQUIPMENT: _____

_____

_____

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 Cancer Respite Program offered by Coastal Family Vacation Foundation, Inc. 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:_____