Corynna's Wish

Corynna's Wish is a nonprofit granting entity that is dedicated to fulfilling wishes that patients and their families cannot accomplish either physically or financially. The organization is dedicated in honor and in memory of Corynna Strawser, a 16-year-old State of the Heart Hospice patient whose inspiring story of her battle with Mitochondrial Disease inspired thousands of people nationally who admired her spirit and tenacity in battling the disease which took her life in 2013. In meeting unmet wishes of the patient and family, the organization hopes to decrease stress and improve quality of life for hospice patients.

Application for Corynna's Wish

Thank you for your interest in Corynna's Wish and for submitting an application. We believe that no wish is too small and we will work to develop and expand the wish you have and will work with the public relations staff to make special arrangements if required. The application must be completed in full to be considered and wish recipients must meet all eligibility requirements. Wishes are fulfilled after consideration and are dependent upon financial and logistical resources. Unless the wish falls within the confines of the categories specified or do not align with the wish mission, they will not be considered. Corynna's Wish exists through the generosity of individual donors and sponsors and reserves the right to deny requests that do not meet criteria. Upon approval, a representative of Corynna's Wish will contact you.

Here Are the Requests We Are Unable to Grant

- Wishes for property, cars or major home remodeling or repair
- Wish for auto repairs
- Wishes of a political nature, legal nature, or considered dangerous to do
- Wishes for cash or bill payments
- Wishes that are to be a surprise
- Wishes for legal needs
- Wishes for travel outside the mainland United States
- Wishes for medical needs such as treatments, equipment, surgery or pharmacy items
- Wishes for people who are not legal residents of the United States
- Wishes for funeral services, cremation, or any service after the death of the patient

Eligibility Requirements for Recipients

- Must not have received a wish from a grant making entity before
- Must be a legal resident of the U.S.
- Must be under the care of State of the Heart Hospice
- Must have no prior felony convictions

Requesting a Wish: How to Do It

You must complete all of the forms attached and be sure to use the checklist to assure all questions and points are replied to. Once you have this completed, mail to: **Business Development Director**, **State of the Heart Hospice, 1350 N. Broadway, Greenville, OH 45331. You can also fax to the director's attention at 937-548-7144 or email to:** mstebbins@stateoftheheartcare.org **If you have questions about any part of the application requirements call 1-800-417-7535 and ask to speak to the Business Development Director.**

Here is the Checklist: Indicate completion with a check mark

1. _____Completed Wish Application
2. _____ A liability waiver signed by the patient or their power of attorney
3. _____ Physician's release form
4. _____ Copy of Do Not Resuscitate form (If appropriate)
5. _____ Media release for marketing purposes signed by patient or power of attorney

Corynna's Wish Application

(Please check appropriate boxes or fill in blanks)

Date (month/date/year) ______________

I am filling out this request on behalf of a wish recipient_____ (Check if appropriate)

My relationship to the patient is_______________________________

I am submitting this application for myself_______ (Check if appropriate)

Wish recipient Information

First Name____

Last Name____

Date of birth: ________

Diagnosis____

<u>Nominator Information</u>

Full name____

Phone number__________________________

Email address______________________________

Alternate phone number_________________________

I am the recipient's Power of attorney________(Check if appropriate) If so provide the following:

Name: (please print) ____

Street: ____ City ____________________ State _____ Zip_____

Phone number: _______________________________ email address: _________________________________

I am NOT the recipient's Power of attorney_________(check if appropriate)

Address:____________________________________ City ______________________State_____Zip _________

Phone: ___________________________ email:_______________________________________

Please provide the following wish information:

1. Detailed description of the wish and why it is important

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2. What level of supervision does the wish recipient require? Will they need a nurse? (Please provide a brief description on what and why)

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____

3. Is the patient ambulatory?

Y___ N___ (Check appropriate box)

IF NO please answer the following as to the need:
What type of wheelchair? (List the type of wheelchair and please be specific)

____

Does the patient need a 2-person transfer?

Y___ N___ (Check appropriate box)

4. Can the patient take food by mouth?

Y___ N___ (Check appropriate box)

IF YES does the patient have any diet restrictions? If YES please list restrictions:

____

5. Is the wish recipient communicative?

   Y____ N____ (Check appropriate box)

6. Is there a specific time frame or date for this wish request? (If so, what is it and why?

   ____
   ____
   ____

7. Please list any participants that the wish recipient would like in attendance if the wish is granted
   ____
   ____
   ____

By signing below, I acknowledge that I understand that this is only an application for a wish and not an agreement that Corynna's Wish will grant the request.

I understand that Corynna's Wish representatives will contact me if my submission has been approved. By signing this form, I certify that the information I have provided is correct to the best of my knowledge, the wish recipient meets eligibility requirements, and that the requested wish falls under the guidelines described on the first page of this form. I agree to notify Corynna's Wish as soon as possible if the information submitted should change.

Print name: ____

Signature: ____ **Date:** ________________

(WAIVER, RELEASE OF LIABILITY AND HOLD HARMLESS AGREEMENT FOR CORYNNA'S WISH)

THIS AGREEMENT is made and entered into on ___________________, between Corynna's Wish through State of the Heart Hospice a nonprofit Ohio corporation and the Wish recipient _________________________________.

I, the undersigned or legal representative, wants to participate in the Corynna's Wish organization recipient wish project.

In consideration for my participation I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE Corynna's Wish or State of the Heart Hospice officers, board or employees, contractors, vendors, agencies, sponsors, officials and volunteers from any and all liability, claims, demands, causes of actions or suits in equity arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in the Corynna's Wish project or while in, on or upon premises where the activity is being conducted or in transportation to and from said activity.

I understand that there could be inherent risks and dangers in participating in the Corynna's Wish project. I hereby elect to voluntarily participate in said activity knowing that the activity may be hazardous to me and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR All RISKS OR LOSSES, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may arise and are sustained by me, or any loss or damage to property owned by me, as a result of being engaged in the Corynna's Wish project whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise.

I agree to INDEMNIFY AND HOLD HARMLESS the releasees from any loss, liability, damage or costs, including court costs and attorney's fees that may occur due to my participation in the Corynna's Wish project whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise.

And furthermore, it is my intent that this Waiver, Release of Liability and Hold Harmless Agreement shall bind to the members of my family and spouse/and/or significant other if I am alive, and to my heirs, assigns and personal representative if I am not alive. If any term, covenant, condition or provision of this Waiver, Release of Liability and Hold Harmless Agreement be invalid, voidable or unenforceable for any reason, such portion of this Agreement shall be severable from the remaining provisions and the invalidity, voidability or unenforceability shall not affect the validity, effect, enforceability or interpretation of the remaining provisions of this Agreement. The remaining provisions will be valid and enforceable to the fullest extent permitted by law. This Agreement shall be construed in accordance with the laws of the State of Ohio. I have carefully read this Waiver, Release of Liability and Hold Harmless Agreement and fully understand the terms and sign it voluntarily on my own free will.

Participant Signature (or Legal Representative)
Print Name ________________________________Signature__________________________Date_____

Corynna's Wish Representative & Title

Print Name________________________________Signature__________________________Date____

Media and Marketing Consent Form

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MEDIA AND MARKETINGPURPOSES

Corynna's Wish and State of the Heart Hospice request your permission to photograph or film you and/ or your relatives to use in our internal and external publications, bulletin boards, web site, social media, magazine articles and/or newspaper articles. The information will be used for the marketing and publicity by State of the Heart Hospice and Corynna's Wish.

FIRST NAME____

LAST NAME____

ADDRESS____

CITY______________________________________State______________Zip _______

PHONE____

Authorization

I hereby authorize Corynna's Wish and State of the Heart Hospice to use and disclose Protected Health Information related to my medical condition for the purpose stated above. This authorization will expire upon revocation of the agreement. Also, I understand this authorization may be revoked at any time prior to the expiration date listed above provided the use or disclosure has not already occurred prior to my request for revocation. To revoke, the patient or legal guardian must notify Corynna's Wish in writing at State of the Heart Hospice, 1350 N. Broadway Greenville, OH, 45331.

Protected Health Information used or disclosed as a result of this Authorization may be re-disclosed by the recipients receiving such information, and is no longer protected by federal privacy regulations.

I agree the photos or images become the property of Corynna's Wish and State of the Heart Hospice or its representative. I understand that I release to Corynna's Wish and State of the Heart Hospice of any right, title and/or interest of any kind it may have in the information or images produced. By signing below, I authorize Corynna's Wish and State of the Heart Hospice to use or disclose Protected Health Information specified in this Authorization.

Signature of Patient/Legal Representative and Date

____ Date ___________________

If Legal Representative, a description of the Legal Representative's authority to act for the Patient should be explained

____

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____

Physician's Release Form for Corynna's Wish

Full name of wish applicant

____

Short description of wish request

____

____

This section is to be filled out by applicant's physician

Physician's name______________________________

Address_____________________________________

City ____________________________State ______________Zip _______

Physician's phone__________________________

Physician's email_______________________________

The wish applicant listed above is currently under hospice care, and I certify that I am the treating physician of the Corynna's Wish applicant. To the best of my knowledge I believe it safe and reasonable if my patient's wish request, as described above, is granted within 60 days.

Physician's Name (Printed) ____

Physician's Signature ________________________________ Date________________