Island Gift of Life Foundation, Inc.
P.O. Box 532
***Shelter Island Heights, New York* 11965**

Dear Friend:
If you are a resident of Shelter Island, Southold, East Hampton or Southampton with a life threatening illness and need financial assistance for uninsured medical and collateral expenses, such as: prescriptions, travel expenses, copays, we encourage you to make an application to the Foundation.

The Board of Island Gift of Life meets monthly and it is at these meetings that new applications are reviewed. If your needs fall within our mission, a committee of two or three board members will be formed. That committee will reach out to you to learn more about how we can best assist you. The committee may also contact your doctor(s) for additional information and or billing departments to inquire about bill reductions.

We respect your privacy and your personal information will remain confidential. The specifics of your application will be disclosed to the committee members working on your case.

We are interested in you as a whole person. You are not just a diagnosis to us. We promise to carefully consider your request and respond as quickly as possible.

Thank you in advance for asking us to help.

Island Gift of Life Foundation *Application*

Date: ________________

Name: ____
Date of Birth: ____
Address: ____
____
Phone: ____

Diagnosis:____

Name of friend or family member we may contact on your behalf regarding your case:
____
Phone: ____
Social Worker we may speak with on your behalf regarding your case:
____
Phone: ____

Our Mission

Our mission is to assist those without insurances or the personal assets to cover needed medical expenses, travel expenses related to treatment, and assist with reducing bills related to treatment for life-threatening illness, when possible.

Your Medical Needs

Along with your application, please provide us with a copy of your physician's description of your medical condition and any information such as specialist's reports regarding your treatment that might be helpful for us to understand your medical situation.

Medical Release

Please be sure to sign and include the medical release form allowing us to contact and discuss your medical situation with your physicians.

Insurance

Are you currently insured? Yes No

Name of company, if insured: ____

Have you applied for other financial assistance or charity reductions for this situation? (Please include any funding sources or grants received.)

Grant(s) received: Agency____

Amount $____

Charity Care: Agency ____

Amount $ ____

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Authorization for Release of Medical & Insurance Records
to the Island Gift of Life Foundation, Inc.

*Patient Name:*____

*Date of Birth:*___________________________

*Insurance Carrier:*____

*Policy Number:*____

I am aware that my medical records may have reference to a psychiatric, drug or alcohol problem and this authorization is intended to include permission to release any information pertaining to my treatment for any such problems, if contained in my medical records.

By authorizing the release of my medical or psychiatric records, I hold the Island Gift of Life Foundation, Inc., its physicians, agents and employees harmless from any consequences which I may suffer directly or indirectly as a result of the release of such records.

This authorization is valid until it is revoked by me. I understand that I can revoke this release at any time upon written notification to the Island Gift of Life Foundation, Inc. except to the extent that the Island Gift of Life Foundation, Inc. may have already released records in reliance upon this release.

____
Witness

____
Patient's Signature or signature of parents, guardian or other person authorized to consent for the patient if a minor (under 18) or otherwise unable to give consent

____
Date Signed

____
Print Name (patient)

____
Relationship to Patient

If drug abuse or alcohol records are involved, this information is disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits re--disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information will not be sufficient for this purpose.