Life Longings Request Form

Dear LL Applicant,

We would love to make your life longing come true! The Friends of Hospice in Oswego County is a not for profit 501(c)3, located upstairs at 3 Creamery Rd. in Oswego, NY.

Applicant Criteria:

- Applications must be filled out completely and submitted by a doctor, family member, individual or representative of an individual with a life limiting diagnosis and prognosis of 12 months or less.
- Recipient must reside in Oswego County.
- Your current physician must sign our release that you, the patient, fits our criteria to participate on the LL request.

Life longings we **CANNOT** grant:

- Cruises.
- Hunting/ fishing excursions.
- Legal or financial assistance.
- Funeral or burial costs.
- Automobiles, boats or RV purchase.
- Rental or Mortgage assistance.
- Medical treatment.
- Privately hired care.
- Transportation provided by the Friends of Hospice.

Examples of Life Longings we **CAN** grant, but not limited to:

- Requests up to $100- final discretion of the committee to approve additional funds.
- Cakes for Celebrations; birthdays, anniversaries etc.
- Fresh Flowers
- Hair/nail care
- Holiday meals
- Facilitate Transportation
- Tickets to a show.
- Cleaning service.

Geographical and monetary limitations may apply. The LL team will have the final discretion to grant your requests.

Section I

General Information

Applicant's Full Legal Name:_____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Phone: _____ Email: _____

Military Veteran: Yes____ or No _____ If yes, Branch and years of service: _____

Clubs/ Organizations/ Hobbies: _____

Contact name: _____Relationship:_____

Address: _____

Phone: _____ Email: _____

Section II

Life Longing Information

LL Applicant Name:_____

Life Longing Request:

_____

_____

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Alternate LL Request: (Secondary request in the case the “LL team” is not able to approve the primary dream request.)

_____

_____

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_____

Section III

Medical Information

LL Applicant/Parent/Guardian signature _____

Relationship to LL Applicant _____

Date of Birth _____

Today's Date _____

This part to be completed by physician only

Physician's Name _____

Physician's Address: _____

Phone Number: _____

Applicant's Current prognosis in months: _____

I certify that I am the physician of _____ (name of applicant.) To the best of my knowledge, the applicant has a current life expectancy of 12 months or less. The applicant is of sound mind and capable to sign legal documents. I have discussed the LL request with the patient and certify it is safe and reasonable for the applicant at this time.

_____ _____ _____

Signature of Physician, PA or NP only Title Date

Life Longings Consent to Publicity

I hereby give permission to the Friends of Hospice in Oswego County to use, publish, or broadcast for the purposes of advertising or other such use as it may determine, all photographic images, video, and audio recordings of myself taken by the staff or their designee, with or without designation of my name.

Any limitations on the use of this material must be made in agreement by the above organization and myself. I will make no financial claims for the use of the materials.

_____.

Name of Patient (Print)

_____.

Signature

_____.

Date

_____.

Relationship to patient (If signed by another person)

Liability Waiver/ Agreement

A. The Friends of Hospice in Oswego County/ Life Longings (FOH/LL) shall assist with the requests for the person identified below (recipient) and participants such as spouse, family members or caregivers are subject to the terms and conditions set forth in this agreement. FOH/LL reserves the right in its sole and absolute discretion to decide if a request will be granted and on what terms. FOH/LL shall have no obligation to fulfill any requests hereunder if it elects to terminate or abandon such requests.
B. The recipient and all participants hereby forever waive any and all rights or claims he or she may hereafter acquire against FOH/LL, its officers, directors, agents, employees or volunteers arising out of any injury, harm, damage, or loss of any kind of body or property, including without limitation the transmission of infectious or communicable disease and/or attorney's fees (collectively "Losses") suffered or incurred by the recipient and any participant, arising out of or in any way related to FOH/LL's preparation, execution or fulfillment of the request, whether or not such Losses were caused by the active, passive or gross negligence of FOH/LL or any other person.
C. Recipient and participants do hereby agree to indemnify and hold FOH/LL its officers, directors, agents, employees and volunteers harmless of and from any and all losses suffered or incurred by FOH/LL as a result of any claim, lawsuit, action arising from the actions or omissions of recipient and participants during the preparation, execution and fulfillment of the request.
D. The expenses FOH/LL has agreed to pay for are those foreseeable and directly related to the fulfillment of the request. Recipient and/ or participants understand they are responsible for all other expenses that were not expressly agreed upon by the FOH/LL team. FOH/LL shall not have any responsibility or liability for expenses incurred by recipient and/or participants which have not been expressly assumed by FOH/LL pursuant to this agreement. It will be the sole responsibility of the recipient to pay for all expenses in excess of those for which FOH/LL has agreed to pay. **If death occurs during a request, FOH/LL is unable to assist in any way.**
E. FOH/LL shall terminate the request after the signing of this agreement if: (1) FOH/LL determines the fulfillment of the request may endanger the health or safety of the recipient or others involved in fulfilling the request. (2) The recipient experiences a decline and the FOH/LL determine the recipient is unable to utilize the request. (3) Recipient passes away prior to request being granted. (4) Recipient has breached any aspect of this agreement, or the request is in violation of the rules, policies, procedures of FOH or NYS laws. (5) The FOH/LL determines in its sole and absolute discretion that the recipient is unable to receive the request.
F. The recipient acknowledges the health and safety risks of certain requests that may involve travel, large crowds or other facets of their request. The recipient will disclose a decline in their medical condition prior to the fulfilment of the request if the deterioration impacts their ability to participate in the request.

By signing below, you acknowledge all information contained in this application is true and correct. You have read this agreement, have retained a copy, and understand and agree to its provisions. All participants must sign the agreement. For any minor participants, the signature of their parent or guardian is both on behalf of the parent or guardian and on behalf of the minor.

Recipient:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Participant:_____ Date:_____

Fulfillment Form

The Friends of Hospice and the Dream Team Committee are able to provide the following for your Life Longing Request:

_____

_____

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_____

Signature of FOH Representative:

_____

Date:

_____

Signature of Life Longing Participant:

_____

Date:

_____