HUGS Application

Thank you for your interest in applying for HUGS – Help, Understanding & Group Support for Hawaii's Seriously Ill Children and Their Families. For more information about our programs and eligibility, please visit our website at www.hugshawaii.org.

This application consists of three forms:

1) Referral Form, including Consent to Exchange Information and Liability Waiver
2) Program Participation Media Release Form
3) Physician's Diagnosis Verification Form

Please have your child's doctor fill out the Physician's Diagnosis Verification Form. This particular form needs to be mailed or faxed to (808)732-4881 *directly from the doctor's office*.

Please mail, email or fax the other completed forms (Referral Form and Media Release Form) to:

HUGS
3636 Kilauea Ave.
Honolulu, HI 96816
Email: family@hugshawaii.org
Fax: (808)732-4881

If you have any questions, please feel free to contact anyone in the Family Services staff at (808)732-4846 or email us at family@hugshawaii.org.

FOR INTERNAL USE ONLY

ENROLLMENT DATE: _____

INPUTTED BY: _____
(Initials)

3636 Kilauea Avenue, Honolulu, HI 96816-2318
Tel.: 732-4846 FAX: 732-4881 Website: www.hugshawaii.org

REFERRAL FORM

Date of Referral:_____ Referring Agency:_____

Name of person referring:_____ Phone:_____

FAMILY INFORMATION

Child's Name: _____ DOB:_____ M( ) F( ) Other_____

Ethnicity:_____ School:_____

Sibling: _____ DOB:_____ M( ) F( ) Other_____

Ethnicity:_____ School:_____

Sibling: _____ DOB:_____ M( ) F( ) Other_____

Ethnicity:_____ School:_____

Sibling: _____ DOB:_____ M( ) F( ) Other_____

Ethnicity:_____ School:_____

Parent/Guardian: _____ DOB:_____ M( ) F( ) Other_____

Relationship to child: _____ Cell Phone: _____ Ok to text ( )

Ethnicity:_____

Employer: _____ Work Phone: _____

Parent/Guardian: _____ DOB:_____ M( ) F( ) Other_____

Relationship to child: _____ Cell Phone: _____ Ok to text ( )

Ethnicity:_____

Employer: _____ Work Phone: _____

Other family members in household: _____

Primary email: _____ Secondary email: _____

Home Address: _____

Mailing Address, if different: _____

Home Phone: _____ Branch of Military Service (if applicable): _____

Marital Status of Parents: _____ Child Resides with: _____

Income Level: ( ) below $30,480 ( ) between $30,481 - $45,720 ( ) $45,721 – $91,440 ( ) above $91,440

MEDICAL INFORMATION

Diagnosis:_____ Date of Diagnosis_____

Hospital: _____

Physician: _____ Physician Phone: _____

CONSENT TO EXCHANGE INFORMATION

I understand that the purpose of this consent form is to better enable HUGS staff to support my family. I hereby give my consent for

HUGS to exchange information regarding my child, _____
(Child's Name)

with my child's physicians, _____
(Names of Physicians)

My child is being treated at_____ for_____

Other providers HUGS may contact include:_____

Signed:_____Date:_____

Print Name: _____Relationship to Child:_____

Witness:_____Date:_____

This consent is good for the duration of my family's affiliation with HUGS or until otherwise revoked.

LIABILITY WAIVER

I, on behalf of myself and/or my minor child(ren), hereby agree as follows:
1) To waive any and all claims, liabilities, actions, damages, penalties, suits, costs or expenses of any nature whatsoever, in law or equity (collectively, "Claims"), that I and/or my minor child(ren) has or may in the future have against HUGS and/or their Agents, and to release HUGS and their Agents from any and all Claims that I and/or my minor child may suffer or that my next-of-kin may suffer as a result of my participation in any of HUGS Activities, to the extent provided by law.
2) To hold harmless and indemnify HUGS and their Agents, from any and all Claims relating to any property damage or personal injury to any third party resulting from my participation in HUGS Activities.
This Liability Waiver and Release Agreement shall be effective and binding upon me, my heirs, next-of-kin, executors, administrators, assigns and representatives, in the event of my death or incapacity. This Agreement shall be governed by and interpreted solely in accordance with the laws of the State of Hawaii and no other jurisdiction. Any litigation involving the parties in this Agreement shall be brought solely within the State of Hawaii.

By signing this Agreement, I acknowledge and represent that: (1) I have read the above waiver and release, understand it, and sign voluntarily; (2) I am over 18 years of age and am of sound mind; (3) I have no known physical or mental condition that would increase the likelihood of serious injury from such participation; (4) I and/or my minor children are receiving consideration for executing this Release by participating in HUGS activities, and I/we would not be able to participate without executing this Release; and (5) in case of emergency, I give permission to have myself and/or my minor child taken to and treated at the nearest available medical facility.

_____ _____ _____
Signature of Parent/Guardian Print Name Date

Revised Date: 02.03.21

Program Participant Release Form for Interviews, Email and Text Messages, Photographs, and Video and Voice Recordings

I, _____, understand that HUGS for Hawaii's Seriously Ill Children and Their Families (HUGS) uses interviews, email and text messages, photographs, videos, and voice recordings of participants taken during HUGS program activities and operations as a means of education, evaluation, documentation, and to raise public awareness of its services.

I authorize HUGS and its designate agents, to interview, photograph, record, film and videotape me and/or the minor children in my care.

I further authorize HUGS to use, televise, and publish (in print or on the Internet, including Facebook and other social media) such interviews, email and text messages, photographs, videos and voice recordings for any purpose which HUGS deems suitable and which is consistent with the mission of HUGS. I agree that no representations or warranties have been made regarding the purpose or use of my interviews, email or text messages, photographs, videos or voice recording, except for those set forth in this release.

On behalf of myself, my heirs, executors, administrators, legal representatives, and assigns, I release and forever discharge HUGS and its Board of Directors, officers, agents and employees from any and every claim, demand action, in law or equity that may arise as a result of HUGS' use or publication (through print, Internet, or television) of its interviews, email or text messages, photographs, voice recordings, films or videotapes of me and/or the minor children in my care.

I further state that I have carefully read the terms of this release. I understand that I am signing a complete release and bar to any claim resulting from HUGS' use or publication of interviews, email or text messages, photographs, voice recordings, videos and other forms of media described herein of me and/or the minor children in my care.

I further understand that this release shall survive the termination of my relationship with HUGS for all media described herein and create during said relationship.

☐ I agree to all of the above.

☐ I disagree, and do not authorize HUGS to interview, photograph, videotape or record me or the minor children in my care for any of its purposes.

_____	_____
Parent or Guardian's Name	Parent or Guardian's Name
_____	_____
Minor's Name	Minor's Name
_____	_____
Minor's Name	Minor's Name
_____	_____
Parent or Guardian's Signature	Parent or Guardian's Signature
_____	_____
Date	Date

PHYSICIAN DIAGNOSIS VERIFICATION FORM

Child's Name:_____ Date of Birth: ___/___/_____

Parents/Guardians:_____

Parents/Family Phone Number:_____

Referring Agency or Hospital: _____

Referral Source Name:_____ Phone number:_____

Attending Physician:_____

Diagnosis:_____

Date of Diagnosis_____

Prognosis: (Please indicate whether you consider the condition to be life-threatening for this patient)

_____

_____

Brief Recommendations for child and/or family support: _____

_____

Additional Referral Information:_____

_____

Physician Signature: _____ Date:_____

THIS FORM MUST BE MAILED/FAXED FROM THE PHYSICIAN'S OFFICE DIRECTLY TO HUGS

Please return to:
HUGS
3636 Kilauea Avenue
Honolulu, HI 96816-2318
PH: (808) 732-4846 Fax: (808)732-4881
www.hugshawaii.org

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