

THE GOLDEN RIBBON FOUNDATION

HELPING WOMEN LIVING WITH GYNECOLOGIC CANCER

APPLICATION PACKET

MISSION

The mission of The Golden Ribbon Foundation is to make complementary treatments and supportive care services available to women in Lane County who have been diagnosed with and are under a physician's care for gynecologic cancer. Complementary treatments and services can help alleviate the pain, nausea, fatigue, stress and anxiety, and other side effects associated with the conventional treatment of gynecologic cancer.

PROGRAM & ELIGIBILITY

The Golden Ribbon Foundation, an Oregon private foundation, provides \$1,000 grants to any female resident of Lane County who has been diagnosed with and is under a physician's care for gynecologic cancer for complementary treatments¹ such as:

- ❖ Massage
- ❖ Acupuncture
- ❖ Reiki/Healing Touch/Energy Therapy
- ❖ Therapeutic Water Classes
- ❖ Nutritional Counseling
- ❖ Movement Therapy: Yoga & Tai Chi
- ❖ Mind/Body Workshop: breathing techniques, meditation, guided imagery, self hypnosis/biofeedback, movement, dancing, writing and drawing

PARTICIPATION

Before beginning any complementary treatment, women undergoing cancer treatment should first discuss this decision with their oncologists, as some complementary and alternative therapies may interfere with standard treatment. As with any medicine or treatment, it is important that women do their own research and learn as much as possible about the therapy. Some questions to ask your health care provider:

- What benefits can be expected from this therapy?
- What are the risks associated with this therapy?
- Do the known benefits outweigh the risks?
- What are the potential side effects?
- Will the therapy interfere with conventional treatment?
- Is this therapy part of a clinical trial? If so, who is sponsoring the trial?
- Is the therapy already covered by health insurance?

APPLICATION PROCEDURE

To apply for a Golden Ribbon Foundation grant, please complete the following:

- 2 page application form
- 1 page oncologist referral form
- 1 page authorization for release of health information (for your referring oncologist or physician)
- 1 page informed consent and acknowledgement of risk form

Submit your application materials to:

The Golden Ribbon Foundation
P.O. Box 10614
Eugene, OR 97440

¹ Treatments covered are subject to change at any time without notice

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APPLICATION (Page 1 of 2)

APPLICANT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone: _____ Evening Phone: _____
Email: _____
Birth Date (mm/dd/yyyy): _____ SS#: _____

PARENT/GUARDIAN INFORMATION (IF APPLICANT IS UNDER THE AGE OF 18)

First Name: _____ Middle Initial: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone: _____ Evening Phone: _____
Email: _____ Relationship to Client: _____

MEDICAL INFORMATION

Have you been diagnosed with gynecologic cancer? YES NO
Are you currently undergoing conventional treatment? YES NO

If yes, briefly describe diagnosis, surgeries and treatment to date: _____

Oncologist Name: _____ Oncologist Phone: _____

INSURANCE INFORMATION

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____
Group Number: _____ Member ID #: _____
Employer: _____
Employee/Name of Insured: _____

Please attach a photocopy of both sides of insurance card.

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INTERESTS

To help us better serve your needs, please indicate the complementary therapies that interest you most:

- | | | |
|---|--|--|
| <input type="checkbox"/> Massage | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Breathing/relaxation techniques |
| <input type="checkbox"/> Reflexology | <input type="checkbox"/> Therapeutic water class | <input type="checkbox"/> Guided imagery |
| <input type="checkbox"/> Watsu (massage in pool) | <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yoga | <input type="checkbox"/> Writing/drawing therapy |
| <input type="checkbox"/> Traditional Chinese medicine | <input type="checkbox"/> Chi Gong | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reiki | <input type="checkbox"/> General exercise | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Healing touch | <input type="checkbox"/> Meditation | |

Please note that some therapies may not always be available.

EXPECTATIONS

Please briefly describe how you expect to benefit from receiving complementary therapies:

COMMENTS (optional)

We welcome your comments and any additional information you would like to provide about yourself and your interest in or experience with complementary therapies.

PLEASE ENSURE THAT ALL SECTIONS ARE COMPLETE AND SIGN BELOW

My signature below affirms that to the best of my knowledge, the information in this application is true and correct. I agree that my eligibility to receive grants requires that I be under the care of an oncologist or physician at all times and that I will immediately notify The Golden Ribbon Foundation should I change doctors or no longer be under the care of the physician/oncologist indicated in this application.

Applicant Signature: _____

Date: _____

Name: _____

If client is under 18:

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name: _____

FOR OFFICE USE ONLY

Date received: _____

Received by: _____

Date approved: _____

Approved by: _____

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ONCOLOGIST/PHYSICIAN REFERRAL FORM

APPLICANT NAME: _____

BIRTH DATE: _____

ONCOLOGIST/PHYSICIAN REFERRAL INFORMATION (TO BE COMPLETED BY REFERRING ONCOLOGIST or PHYSICIAN)

Applicant may participate in the following treatments (initial each line)

- | | | |
|---|--|--|
| <input type="checkbox"/> Massage | <input type="checkbox"/> Therapeutic Water Class | <input type="checkbox"/> Techniques |
| <input type="checkbox"/> Reflexology | <input type="checkbox"/> Nutritional Counseling | <input type="checkbox"/> Guided Imagery |
| <input type="checkbox"/> Watsu (massage in pool) | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Yoga | <input type="checkbox"/> Writing/drawing therapy |
| <input type="checkbox"/> Traditional Chinese medicine (herbs) | <input type="checkbox"/> Chi Gong | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reiki | <input type="checkbox"/> General exercise | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Healing Touch | <input type="checkbox"/> Meditation | |
| | <input type="checkbox"/> Breathing/Relaxation | |

Applicant may not participate in the following therapies or activities: _____

Other concerns and comments: _____

REFERRING ONCOLOGIST/PHYSICIAN INFORMATION

Oncologist Name: _____

Phone: _____

Fax: _____

Address: _____

City: _____

State: _____

Zip: _____

Daytime Phone: _____

Email: _____

AUTHORIZED SIGNATURE

My signature below affirms that Applicant has received a diagnosis of gynecologic cancer and is currently under my care.

Oncologist/Physician Signature: _____

Date: _____

FOR GOLDEN RIBBON FOUNDATION OFFICE USE ONLY

Date received: _____

Received by: _____

Date approved: _____

Approved by: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION: HIPPA

I authorize _____ (name of health provider) to use and disclose a copy of the health information described below regarding me, _____, to the **Golden Ribbon Foundation** for the purpose of applying for services provided by the **Golden Ribbon Foundation**. The health information to be used and disclosed includes the information specifically authorized below, as well as all other information in my health records relevant to the above-described purpose.

_____ By initialing here, I specifically consent to disclosure of my HIV/AIDS information.

_____ By initialing here, I specifically consent to disclosure of my mental health information.

_____ By initialing here, I specifically consent to disclosure of my genetic testing information.

_____ By initialing here, I specifically consent to disclosure of my drug and/or alcohol diagnosis, treatment or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer be protected under federal law.

PRINT PATIENT'S NAME _____ DATE _____

BY: _____
SIGNATURE OF PATIENT

1. You may inspect a copy of the protected health information to be used or disclosed;
2. You may refuse to sign this Authorization; and
3. We must provide you with a copy of this signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

To revoke this Authorization, please contact our President.

Unless revoked earlier or otherwise indicated this Authorization shall remain in effect.

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INFORMED CONSENT AND CONSIDERATION OF RISK

In consideration for the opportunity to apply for a grant from The Golden Ribbon Foundation (the Foundation), the undersigned applicant understands and agrees that:

1. there may be medical risk in undergoing the complementary and/or alternative treatments sponsored by the Foundation, including interference with standard cancer treatments;
2. the Applicant assumes all risk of and financial responsibility for any loss or injury related directly or indirectly to receiving treatments sponsored by the Foundation and agree to indemnify and hold the Foundation harmless from and against any and all costs, claims, demands, charges, liabilities, obligations, judgments, executions, costs of suit and actual attorneys' fees incurred or suffered by the Applicant as a result of, or arising out of, the Applicant's participation in any course of treatment sponsored by the Foundation, except for claims resulting wholly from the gross negligence of the Foundation;
3. the Foundation itself is not a medical expert or provider of any medical services and makes no determination as to whether Foundation-sponsored treatments are advisable or appropriate for the Applicant; participation in any treatment program is voluntary and the Applicant agrees to evaluate the risks of receiving complementary and/or alternative treatments independently and with the aid of her oncologist(s) and/or other medical professionals to determine if the treatments are appropriate for her and her medical and personal needs;
4. all aspects of the Foundation grant program including, without limitation, the services covered, the criteria for participation, and the application and review process are subject to change at any time, without notice, at the Foundation's sole discretion based on the availability of services, funding, and the best interests of the Foundation and the public;
5. the massage therapists, acupuncturists, nutritional counselors, and other instructors and Foundation service providers may require additional consent and release forms prior to allowing the Applicant to receive treatment;
6. the Applicant and the Foundation submit to the jurisdiction of the courts of the State of Oregon for the enforcement of this agreement or any arbitration award or decision arising from this agreement. This agreement will be enforced or construed according to the laws of the State of Oregon and the venue for any dispute will be Lane County, Oregon.

This Informed Consent and Acknowledgement of Risk may not be amended, supplemented, or abrogated without the written consent of The Golden Ribbon Foundation.

The undersigned applicant has read and understood the content of this Informed Consent and Acknowledgment of Risk and executes this agreement freely and voluntarily.

Signature: _____ Date: _____

Name: _____

If applicant is under 18:

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____

FOR OFFICE USE ONLY

Date received: _____ Received by: _____

Date approved: _____ Approved by: _____