THE KAICOMBEY FOUNDATION

FREE EMERGENCY MEDICAL FUND APPLICATION FORM

SERVICE TO HUMANITY

This form is used to seek / apply for medical help from The Kaicombey Foundation.
The Kaicombey Emergency Medical fund is used to pay 50% or 100% of medical bills or medical facility costs as the case and circumstance may apply to the beneficiaries. It is specifically established as to complement the efforts of other organizations and the government to fight and reduce the high rate of child and maternal mortality rate, and communicable diseases in the interior part of the country where the situation is visible and challenging.

The emergency medical fund criteria support the patient , based on the socio-economic effect of the illness, what the patient can afford in fees and travel, and the quality of healthcare facility needed. The Fund's main aim and focus is to reduce the mortality rates, with special attention to infants and pregnant women in the rural areas. As an organization deeply concerned with human rights and social justice, the Foundation views this venture as fundamentally rights-based approach.

Access to healthcare is part of human rights!

Please note that incomplete forms will not be accepted. Attach all relevant documents that will explain and support your claim and circumstance.

It is a most that, all applicants are to fill out all the required pages 1 – 5, of this application form.

Full Legal Name of applicant: _____
Date of Birth: _____ Age: _____ Gender: _____

Doctor's Information
Doctor's Name: _____
Doctor's Address: _____
Doctor's Office Phone: _____ Doctor's Emergency Phone: _____

Name and address of Hospital / clinic:
_____

_____

Diagnosis and note any other significant medical information_____
_____
_____
_____

Parent(s)/Legal Guardian(s):

Parent / Guardian (if applicable)
Name: _____
Address: _____
Contact phone: _____
Email: _____

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Additional Contact Information:
_____
_____
_____

Parent #2:

Name: _____
Address: _____
Contact phone: _____
Email: _____
Additional Contact Information: _____
_____

Alternate contact in the event Parent(s)/Legal Guardian(s) cannot be reached:

Name: _____
Address: _____
Contact phone: _____
Email: _____

Total medical bill: _____ _____
(Amount in words) (Amount in fig.)

REMARK (official use only)

_____
_____
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AUTHORIZATION FOR DOCTOR/S, NURSES TO RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to furnish medical information concerning
(Name of medical doctor / in charge nurse)

_____ to The Kaicombey Foundation For Sustainable Development
(Name of Patient)

Any information may be released, including but not limited to both mental and physical health records that is protected by medical privacy Act, drug and/or alcohol abuse records and/or HIV test results.,
This authorization is effective now.

_____ _____ (Date)
Signed of Patient / parent or guardian of minor patient (to an extent that minor could not have consented to the care)

_____
Print Name

_____
(If not signed by the patient, please indicate relationship)

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CLAIM FOR MEDICAL SUPPORT (Explain your circumstance)

Please briefly describe your reason(s) for requesting financial support from The Kaicombey Foundation emergency medical fund. Write not more than one page. Also, list your medical expenses, feeding and supplies if applicable. Please attach copies (not originals) of your medical expenses. Indicate all the charges that are applicable to you. Write on the space below.

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Permission to The Kaicombey Foundation for the use of my information

It is the responsibility of The Kaicombey Foundation to bring to your notice, the use of your information that include any or all written lists, your pictures, audio and video recording, emails, files or data collected material for promotional purposes of the organization.

The Kaicombey Foundation respects your rights to privacy and protection of information.Your privacy is very important and paramount to us.

Our policy is design to seek your consent to make important decession and disclosures about how we can use , collect and or share your information / content, like videos and photos with the public through our website or other medium / forum.
My name and signature below confirms that I…… accept and authorize The Kaicombey Foundation
(insert your first and last name)
to use whatever information collect from / about me. I specifically give The Foundation permission for use in news, stories or promotional materials for the purpose of the Foundation.

PLEASE NOT THAT YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS PERMISSION FORM !

_____ _____
NAME OF APPLICANT / PARENT /GUARDIAN SIG /DATE

I hereby declare that all the information provided on this application is complete and true. Therefore, consent and authorize the disclosure to the Emergency medical committee of The Kaicombey Foundation any information from my doctor, Nurse/s, family members, person/s, and private or public organization, which would assist in determining my eligibility for the said financial assistance towards my medical condition. I also grant the Foundation permission to release my name and address to the donor of any support I might receive.
That should I recover, I will notify The Kaicombey Foundation about my medical condition and grant the Foundation permission to request and receive information pertaining to my medical progress.

Name of Applicant: _____ Signature of Applicant _____ Date: _____
(Please print your name)

We promote & support international Solidarity, advocate, and defend environmental Justice, protect Human and Peoples Rights, Fundamental & Social Justice.