RELIABLE HEALTH PATIENT ASSISTANCE PROGRAM
APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT NAME:		
DATE OF BIRTH:	**SEX:** **MALE** ☐ **FEMALE** ☐	
PATIENT MAILING ADDRESS:		
CITY	**STATE**	**ZIP CODE**
PERSONAL REPRESENTATIVE NAME:		
PERSONAL REPRESENTATIVE ADDRESS:		
CITY	**STATE**	**ZIP CODE**
CELL PHONE	**EMAIL**	
MONTHLY INCOME OF PATIENT	**SOURCE OF MONTHLY INCOME**	
DOES PATIENT HAVE MEDICARE INSURANCE	**YES** ☐ **NO** ☐	
MEDICARE NUMBER		
TERMINAL ILLNESS DESCRIPTION:		

I hereby certify the above information is true and accurate to the best of my abilities.

SIGNATURE
PRINT NAME OF PERSON SIGNING ABOVE
DATE

MARKE FOUNDATION
RELIABLE HEALTH PLACEMENT ASSISTANCE PROGRAM AGREEMENT

Marke Foundation, is a 501(c)(3), IRS approved, non-profit Delaware corporation. Marke Foundation provides financial assistance for senior placement applicants that need assisted living services while encountering terminal illness.

Authorization to Disclose Information:

I authorize Marke Foundation, its agents, third-party contractors, and its service providers to use the information that I provided on the Marke Foundation application form to determine the senior applicant's eligibility for and assist with continued participation in the Reliable Health Placement Assistance Program.

For these purposes, I authorize physicians, healthcare professionals, care givers and family members to disclose to Marke Foundation, its agents, third-party contractors, and its service providers information about the senior applicant.

Patient and/or Patient's personal representative herby understand, acknowledge, and agree to the following:

1) Marke Foundation shall have sole discretion in which facility Patient is placed, but Patient and Patient's personal representative may reject any placement and this agreement will be terminated.
2) Patient will use the hospice company assigned by Marke Foundation and may not change hospice companies while receiving benefits from Marke Foundation.
3) Marke Foundation will maintain patient's information in compliance with state and federal rules and regulations, including HIPAA.
4) Patient shall disclose any and all prior hospice services to Marke Foundation in writing and the dates of hospice services prior to Marke Foundation financial assistance being provided.
5) Marke Foundation may terminate services and assistance under the Agreement if Patient and/or Patient's personal representative have made false or misleading statements to Marke Foundation, violate any terms of this Agreement, or any terms of the facility in which the Patient is placed.
6) Patient or Patient's personal representative understand, acknowledge, and agree that Marke Foundation will be paying in full or in part for a maximum of thirty (30) days for Patient to stay in the facility under Marke Foundation's Reliable Health Placement Assistance Program. After the thirty (30) days, Patient and/or Patient's personal representative shall be responsible for all payments to the facility where the Patient is placed by Marke Foundation.
7) Marke Foundation shall not be responsible or liable for payments, after the thirty (30) days, to the facility, where Patient is placed by Marke Foundation.
8) After 30 days, patient can reapply as a new applicant for the Reliable Health Placement Assistance Program.
9) I understand that in accordance with Federal Regulations: 20 CFR 416.1102, 416.1103, and 416.1145, as interpreted by the Social Security Administration, any contribution given by Marke Foundation to a licensed living facility on behalf of a SSI/SSP recipient shall be used by the facility for care and supervision. No portion of the contribution shall be used for food, clothing or shelter. As a result of compliance with this policy, no portion of Marke Foundation's contribution shall be considered income to the SSI/SSP recipient as interpreted by the Social Security Administration.

I certify that:

The information that I have provided on the Marke Foundation application form is truthful, complete, and accurate.

No Guarantee of Eligibility:

I understand that by completing Marke Foundation's application form, there is no guarantee of eligibility for Marke Foundation's Reliable Health Placement Assistance Program. Approval is subject to the sole discretion of Marke Foundation's management. I understand that Marke Foundation may change or discontinue the Reliable Health Placement Assistance Program within ten (10) days written notice from date of mailing to senior applicant and their listed representative in this application, via certified mail or electronic mail.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority to Sign for Patient
(Attach documents which show authority)

FOR OFFICE USE ONLY

DATE APPLICATION RECEIVED: EMPLOYEE SIGNATURE: