



# EverHeart

## HOSPICE

### Corynna's Wish

Corynna's Wish is a nonprofit granting entity that is dedicated to fulfilling wishes that patients and their families cannot accomplish either physically or financially. The organization is dedicated in honor and in memory of Corynna Strawser, a 16-year-old EverHeart Hospice patient whose inspiring story of her battle with Mitochondrial Disease inspired thousands of people nationally who admired her spirit and tenacity in battling the disease which took her life in 2013. In meeting unmet wishes of the patient and family, the organization hopes to decrease stress and improve quality of life for hospice patients.

#### Application for Corynna's Wish

Thank you for your interest in Corynna's Wish and for submitting an application. We believe that no wish is too small and we will work to develop and expand the wish you have and will work with the public relations staff to make special arrangements if required. The application must be completed in full to be considered and wish recipients must meet all eligibility requirements. Wishes are fulfilled after consideration and are dependent upon financial and logistical resources. Unless the wish falls within the confines of the categories specified, they will not be considered. Corynna's Wish exists through the generosity of individual donors and sponsors and reserves the right to deny requests that do not meet criteria. Upon approval, a representative of Corynna's Wish will contact you.

#### Requests We Are Unable to Grant

- Wishes for property, cars or major home remodeling or repair
- Wishes for auto repairs
- Wishes of a political nature, legal nature, or considered dangerous to do
- Wishes for cash or bill payments
- Wishes that are to be a surprise
- Wishes for legal needs
- Wishes for travel outside the mainland United States
- Wishes for medical needs such as treatments, equipment, surgery or pharmacy items
- Wishes for people who are not legal residents of the United States
- Wishes for funeral services, cremation, or any service after the death of the patient



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### Eligibility Requirements for Recipients

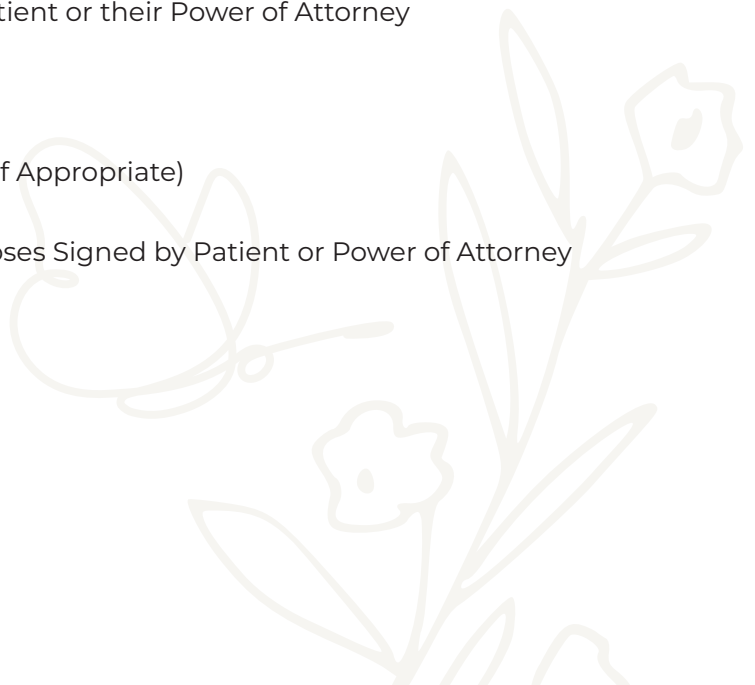
- Must not have received a wish from a grant making entity before
- Must be a legal resident of the U.S.
- Must be under the care of EverHeart Hospice

### Requesting a Wish: How to Do It

You must complete all of the forms attached and be sure to use the checklist to assure all questions and points are replied to. Once you have this completed, mail to: Chief Business Development Officer, 1350 N. Broadway St. Greenville, OH 45331. You can also fax to CBDDO's attention at 844-905-1347 or email to: [bell@ehhospice.org](mailto:bell@ehhospice.org). If you have questions about any part of the application requirements call 1-800-417-7535 and ask to speak to the Chief Business Development Officer.

### Here is the Checklist. Indicate completion with a check mark:

- Completed Wish Application
- A Liability Waiver Signed by the Patient or their Power of Attorney
- Physician's Release Form
- Copy of Do Not Resuscitate Form (If Appropriate)
- Media Release for Marketing Purposes Signed by Patient or Power of Attorney





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### Corynna's Wish Application

Please check appropriate boxes of fill in the blanks.

Date: \_\_\_\_\_

I am filling out this request on behalf of a wish recipient:  
My relationship to the patient is: \_\_\_\_\_

I am submitting this application for myself

#### Wish Recipient Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

#### Nominator Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

I am the recipient's Power of Attorney  
If yes, provide the following:

I am NOT the recipient's Power of Attorney

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_



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### Please provide the following wish information:

1. Detailed description of the wish and why it is important \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What level of supervision does the wish recipient require? Will they need a nurse?  
Please provide a brief description on what and why.  
\_\_\_\_\_  
\_\_\_\_\_

3. Is the patient ambulatory?  Yes  No  
IF NO please answer the following as to the need:  
What type of wheelchair? (List the type of wheelchair and please be specific)

\_\_\_\_\_  
Does the patient need a 2-person transfer?  Yes  No

4. Can the patient take food by mouth?  Yes  No  
IF YES does the patient have any diet restrictions? If YES please list restrictions:

\_\_\_\_\_

5. Is the wish recipient communicative?  Yes  No

6. Is there a specific time frame or date for this wish request? (If so, what is it and why?)

\_\_\_\_\_  
\_\_\_\_\_

7. Please list any participants that the wish recipient would like in attendance if the wish is granted:

\_\_\_\_\_  
\_\_\_\_\_



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**By signing below, I acknowledge that I understand that this is only an application for a wish and not an agreement that Corynna’s Wish will grant the request.**

I understand that Corynna’s Wish representatives will contact me if my submission has been approved. By signing this form, I certify that the information I have provided is correct to the best of my knowledge, the wish recipient meets eligibility requirements, and that the requested wish falls under the guidelines described on the first page of this form. I agree to notify Corynna’s Wish as soon as possible if the information submitted should change.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Waiver, Release of Liability and Hold Harmless Agreement for Corynna’s Wish

THIS AGREEMENT is made and entered into on \_\_\_\_\_, between Corynna’s Wish through EverHeart Hospice, a nonprofit Ohio corporation, and the Wish recipient \_\_\_\_\_.

I, the undersigned or legal representative, wants to participate in the Corynna’s Wish organization recipient wish project.

In consideration for my participation I hereby RELEASE, WAIVE, DISCHARGE AND COVENANT NOT TO SUE Corynna’s Wish or EverHeart Hospice officers, board or employees, contractors, vendors, agencies, sponsors, officials and volunteers from any and all liability, claims, demands, causes of actions or suits in equity arising out of or related to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES, or otherwise, while participating in the Corynna’s Wish project or while in, on or upon premises where the activity is being conducted or in transportation to and from said activity.



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### Continued

I understand that there could be inherent risks and dangers in participating in the Corynna's Wish project. I hereby elect to voluntarily participate in said activity knowing that the activity may be hazardous to me and my property. I VOLUNTARILY ASSUME FULL RESPONSIBILITY FOR ALL RISKS OR LOSSES, PROPERTY DAMAGE OR PERSONAL INJURY, INCLUDING DEATH, that may arise and are sustained by me, or any loss or damage to property owned by me, as a result of being engaged in the Corynna's Wish project whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise.

I agree to INDEMNIFY AND HOLD HARMLESS the releasees from any loss, liability, damage or costs, including court costs and attorney's fees that may occur due to my participation in the Corynna's Wish project whether CAUSED BY THE NEGLIGENCE OF THE RELEASEES or otherwise.

And furthermore, it is my intent that this Waiver, Release of Liability and Hold Harmless Agreement shall bind to the members of my family and spouse/and/or significant other if I am alive, and to my heirs, assigns and personal representative if I am not alive. If any term, covenant, condition or provision of this Waiver, Release of Liability and Hold Harmless Agreement be invalid, voidable or unenforceable for any reason, such portion of this Agreement shall be severable from the remaining provisions and the invalidity, voidability or unenforceability shall not affect the validity, effect, enforceability or interpretation of the remaining provisions of this Agreement. The remaining provisions will be valid and enforceable to the fullest extent permitted by law. This Agreement shall be construed in accordance with the laws of the State of Ohio. I have carefully read this Waiver, Release of Liability and Hold Harmless Agreement and fully understand the terms and sign it voluntarily on my own free will.

#### Participant's Signature (or Legal Representative)

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### Corynna's Wish Representative & Title

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Media and Marketing Consent Form

AUTHORIZATION AND RELEASE FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MEDIA AND MARKETING PURPOSES

Corynna's Wish and EverHeart Hospice request your permission to photograph or film you and/ or your relatives to use in our internal and external publications, bulletin boards, web site, social media, magazine articles and/or newspaper articles. The information will be used for the marketing and publicity by EverHeart Hospice and Corynna's Wish.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Authorization

I hereby authorize Corynna's Wish and EverHeart Hospice to use and disclose Protected Health Information related to my medical condition for the purpose stated above. This authorization will expire upon revocation of the agreement. Also, I understand this authorization may be revoked at any time prior to the expiration date listed above provided the use or disclosure has not already occurred prior to my request for revocation. To revoke, the patient or legal guardian must notify Corynna's Wish in writing at EverHeart Hospice, 1350 N. Broadway St. Greenville, OH, 45331.

Protected Health Information used or disclosed as a result of this Authorization may be re-disclosed by the recipients receiving such information, and is no longer protected by federal privacy regulations.

I agree the photos or images become the property of Corynna's Wish and EverHeart Hospice or its representative. I understand that I release to Corynna's Wish and EverHeart Hospice of any right, title and/or interest of any kind it may have in the information or images produced. By signing below, I authorize Corynna's Wish and EverHeart Hospice to use or disclose Protected Health Information specified in this Authorization.



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## Participant's Signature (or Legal Representative)

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If Legal Representative, a description of the Legal Representative's authority to act for the Patient should be explained:

\_\_\_\_\_  
\_\_\_\_\_

## Physician's Release Form for Corynna's Wish

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Short description of wish request: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## This section is to be Filled out by Applicant's Physician

Physician's name: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

The wish applicant listed above is currently under hospice care, and I certify that I am the treating physician of the Corynna's Wish applicant. To the best of my knowledge I believe it safe and reasonable if my patient's wish request, as described above, is granted within 60 days.

Physician's Name (Print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_