PASSENGER INFORMATION

Appointment Date: _____Outgoing Date: _____Return Date: _____

Patient Info:
First Name: _____ Last Name: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work phone: _____

Email: _____ Cell Phone:_____

Date of Birth: _____ Male____ Female____ Age: _____ Weight: _____

Medical Condition:_____

_____

Home Doctor: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

_____

Destination Treatment Facility:_____

Treatment Doctor:_____

Address: _____ Phone:_____

City: _____State:_____Zip:_____ Fax: _____
_____

Passenger Name	**Weight**	**Age**	**Relationship**	**Phone**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical Equipment: _____Weight:_____

Baggage cannot exceed 40 pounds per trip.

Aviation Angels of Hope, Inc.
Fax: 800-794-7719

Pre-Flight Information

As with any mode of transportation, certain risks are present. You should also know that the same regulatory standards that apply to commercial charter or airline flights are not required to be followed by the volunteer pilot conducting your flight. Specific questions about how your flight should be addressed to the volunteer pilot for the flight.

Please remember that Aviation Angels of Hope's Pilots are volunteers. They are not compensated or reimbursed for any of the costs involved in flying their own or rented aircraft. Please do not offer them payment of any kind since this would alter the flight status from charitable to commercial (as per FAA regulations). It is the generous and kind spirit of these individuals which makes it possible for us to offer our services at no charge so please don't forget to say Thank You!

Please read the following carefully and feel free to call us if you have questions.

General Information about Aviation Angels of Hope flights:

- **You are responsible for being on time, and arranging your ground transportation, lodging/food while traveling;**
- **Do not arrive with an unexpected support person. The Pilot may not have room or capacity for added weight. Also, Pilots often fill an empty seat with a Co-Pilot;**
- **The aircraft are small, 4-6 seats. You cannot lie down or walk around; there is no bathroom on board so visit airport facilities before departure;**
- **Bring adequate personal items, clothing change, and supplies in the event of a delay; Bring cash and/or a credit card with you for unforeseen expenses in case your trip is delayed due to bad weather or other problems;**
- ***Only minimal luggage is allowed*. One or two small to medium soft bags which do not exceed a 40 pound total. Additional luggage may have to be shipped at your expense. Luggage and personal effects may be subject to inspection;**
- **If the date or time of your trip changes, you must immediately contact the Aviation Angels of Hope Mission Coordinator at 888-610-5510. *This is extremely important!***
- **All flights are weather dependent. You are responsible for having a back-up travel plan if it is critical for you to keep your appointment;**
- **The Pilot will call you to confirm time/place of departure about 24 hours beforehand;**
- **Your Pilot will designate your flight as a "compassion flight" with air traffic control;**
- **No smoking is allowed in or near any aircraft.**
- **Do not play with or move any aircraft parts of the aircraft, and do not step on the wing or try to enter the aircraft without specific instructions from the Pilot;**
- **Leave the aircraft clean and report any damage or problem to the Pilot.**

I have read the above and understand my responsibilities regarding my acceptance of this free flight. I realize that the Pilot retains the right to cancel due to changing weather or other circumstance. Also, it is my responsibility to have a realistic back-up plan and be prepared for unforeseen delays and have the financial resources to deal with this situation.

_____

Printed Name

_____ _____

Signature **Date**

Please tell us your back-up plan. Thank you.

I have been informed and understand that the weight limit for baggage is 40 pounds for Aviation Angels of Hope flights. If baggage exceeds the weight limit, it is the responsibility of the passenger to ship their baggage prior to the flight at their own expense. If baggage exceeds the 40 pound weight limit, the flight may be canceled at the discretion of the pilot. By signing this form, I acknowledge that I fully understand and agree to these terms.

Signature: _____
Date: _____

Aviation Angels of Hope, Inc.
Phone: 888-610-5510
Fax: 800-794-7719

Financial Qualification Form

We require written verification that the patient/passenger and family have a legitimate need for help with travel expenses. Generally, we need to know that recipient's insurance will not cover travel expenses, that their income is insufficient to bear the cost of an airline ticket(s), and that they have no other reliable means of transportation. This form must be completed every six (6) months by a professional person (social/case worker, clergyperson, physician, accountant, attorney, employer or staff person of a charitable organization, *not* a family member, personal friend or neighbor.)

Flight Recipient's Name: ________

Give a thorough and specific explanation as to why the individual cannot afford transportation. Include important information that supports their case of financial need. Also, please describe their physical/mental willingness to fly in a small, unpressurized aircraft. Insufficient information or too brief of an explanation may result in the individual not being accepted or the form returned to you for further explanation. An additional page may be used.

_____

_____

_____

_____

_____

_____

By signing this form, I acknowledge that I am familiar with the prospective passenger and their financial needs. The above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

_____ _____

Title/Relationship: Phone Number

_____

Name and Address of Agency being represented

Aviation Angels of Hope, Inc.
Phone: 888-610-5510
Fax: 800-794-7719

Physician's Release Form
(Confidential)

FAA-certified Aviation Angels of Hope Pilots are volunteers who provide people in medical and financial distress with access to free air transportation on small, private, unpressurized aircraft for healthcare and other compelling human needs. Children under the age of 18 must be accompanied by a parent, guardian, or other authorized adult. This release must be re-submitted annually in order for the patient to qualify for on-going medical flights, and re-submitted for each invasive surgery.

Aviation Angels of Hope cannot accept any patient, nor schedule any mission, until this form is completed and signed by the patient's current physician.

- Medical equipment or personnel are ***not*** provided or on board;
- Patients must be ambulatory or mobile enough to board and disembark with little or no assistance. Boarding will require a high step of 12-20 inches. Low-wing aircraft require boarders to take several steps on the wing. Passengers have to be flexible in boarding and departing the aircraft and must be upright and seat-belted for the duration of the flight;
- The aircraft generally used are single or twin engine prop aircraft with 4-6 seats, and privately owned or rented by the pilot. There are no restrooms and space for movement is restricted;
- Most aircraft are not pressurized and oxygen levels vary with altitude (generally below 10,000 feet);
- Turbulence is more pronounced on a small aircraft than on a commercial aircraft;
- The flying time is longer than on a commercial aircraft, there is little wait, thus overall travel time is generally shorter;
- Patients are often accompanied by a support person for assistance during the flight.

By signing this form, you are giving your medical consent to fly under the conditions described above. Please type or print legibly. Thank you.

_____

Patient Name

_____

Physician Name Physician Specialty

_____

Physician's Current License No. and State Expiration Date

_____

Physician Address

(_____)_____

Physician's Phone

Facility Patient will be traveling to: _____

In layman's terms, describe the patient's diagnosis for this flight (or series of flights):
_____
_____

To the best of your knowledge, does the patient, or anyone accompanying the patient, currently have a communicable or contagious disease? ____No; ____Yes;
Explain: _____

To the best of your knowledge, does the patient, or anyone accompanying the patient, currently have any other circumstance, medical or physical, that would preclude travel in an unpressurized aircraft? ____No; ___Yes; Explain: _____

Is there any other information that you feel might be helpful for the Pilot to know about this patient? (i.e. equipment, medications, oxygen, flight concerns) ___No; ___Yes;
Explain_____

If treatment requires a series of flights, is the patient's condition expected to remain stable? ___No; ___Yes; Explain:_____

Is the patient able to walk and get in and out of the aircraft unassisted? (Boarding may require a high step, 12-20 inches, or several steps onto the wing of the aircraft. Passengers have to be flexible in boarding and departing the aircraft.) ___Yes; ___No;
Explain:_____

REMINDER: There is no medical equipment or medical personnel on board, and if the patient will be bringing oxygen, the tanks must be full, portable, and medically-approved. Please realize that oxygen levels can vary in an unpressurized aircraft and may be cause for concern for certain medical conditions.

Is the patient medically stable and able to fly in a small, unpressurized aircraft? ___Yes; ___ No;
Explain:_____

If the patient requires assistance while in flight with medication, oxygen and/or personal medical equipment, to the best of your knowledge, is the support person/passenger trained to assist?
___Yes; ___ No; Comments:_____

To the best of my knowledge, the patient being considered for this flight is physically mobile, and psychologically able and willing to fly in a small, unpressurized aircraft that is not equipped for any medical emergency. This patient has a legitimate medical need to avoid lengthy ground transportation. I have carefully read and completed the above information and approve this patient for flight.

_____
Physician's Signature Date

Please Fax this completed form to 800-794-7719.

Aviation Angels of Hope, Inc.
P.O. Box 615
Manito, IL 61546
Phone: 888-610-5510

General Flight Authorization, Release of Liability, and Indemnity Form

You must complete all blanks and sign this Agreement if you will be a passenger (patient or support) on an Aviation Angels of Hope, Inc. flight, or you are a parent, guardian or other legally authorized person able to consent to a flight for a minor and/or supporting passenger (hereinafter referred to as a "Minor") or an adult patient unable to provide his/her own consent (hereinafter referred to as an "Other Individual.") By signing this Agreement, you agree that in exchange for this free air transportation, you, the Minor and/or Other Individual, if applicable, are giving up any rights to recover damages in the event of your and/or the Minor's/Other Individual's death, injury, property loss or any other loss arising from an accident, incident, cancellation or delay in connection with any such flights.

I, on behalf of myself and the Minor(s)/Other Individual(s), if applicable, acknowledge that:

1) Aviation Angels of Hope, Inc. (hereinafter referred to as AAH), and other assisting Volunteer Pilot Organizations, facilitate access to free air transportation through FAA-certified volunteer pilots who have offered their assistance to fly me and/or to the referenced Minor/Other Individual. AAH does not provide aircraft nor does it control the conduct of the flight. The Volunteer Pilot and aircraft owners are solely responsible for the conduct of the flight and for the aircraft provided.

2) By signing this Release Agreement, I understand that the services donated on my behalf, in the form of time, services, aircraft, and flight expenses being furnished by the Pilot, Co-Pilot, and aircraft owner constitute a significant value and material personal benefit in exchange for this release. I regard such transportation as a significant material factor in my well-being and physical prosperity and, if applicable, that of the Minor/Other Individual that is the passenger for whom the flight is being conducted and for whom I am consenting;

3) AAH and its volunteer Pilot(s) and aircraft owner(s), relying on this general release, may provide air transportation to assist passenger(s) on one or more occasions to obtain and/or return from prescribed medical treatment/evaluation or other medically related purposes;

4) As a non-commercial, non-profit volunteer organization, volunteer pilots and aircraft owners will not be financially reimbursed for their services or the expenses of this flight by neither AAH nor patients/passengers served. The volunteer Pilots will provide the pilot services and aircraft for the air transportation described above, free of charge, at the request of and for the assistance of the patient and any supporting persons identified below;

5) The accomplishment of the objective of the flight is not guaranteed;

6) These flights are flown by the Pilot alone. No crew assistance is provided. Passengers are personally responsible for entering and exiting the aircraft without assistance from the Pilot. The passengers are responsible for providing their own support or assistance. The Pilot may be unable to provide assistance to passengers in exiting the aircraft in the event of an emergency. If additional assistance is needed, the passenger is responsible for providing his/her own personal assistant, and advance arrangements must be made with AAH Mission Coordinators.

7) All patients/passengers are responsible for their own ground transportation, room and board arrangements and expenses, both scheduled and unplanned, in the event of a flight delay or cancellation.

In consideration for receiving aircraft and Pilot services provided free of charge, I personally and on behalf of the Minor/Other Individual, if applicable, agree with respect to each such flight:

1) While in or about the aircraft, to assume all risk of damage or injury, including death, however caused, as well as the risk that the objective of a flight may not be accomplished;

2) That neither I, the Minor/Other Individual, or any of my/their heirs, representatives or assigns will make any claim or bring any cause of action against Aviation Angels of Hope, Inc., the Pilot(s) and aircraft owner(s) as a result of any personal injury, wrongful death, property damage or other loss or damage occurring while in or about the aircraft or in connection with the flight, irrespective of cause. I/they hereby release and hold harmless Aviation Angels of Hope, Inc., the Pilot(s) and the aircraft owners(s) from any such claims or suits.

3) To protect and hold harmless, undertake the defense of, and fully indemnify Aviation Angels of Hope, Inc; their members, directors, officers, employees and volunteers; the volunteer Pilot(s); the aircraft owner(s); and their heirs, assigns, and successors in interest from all loss, liability, damages, fees, costs, and expenses of **defense of any suit** brought by any party relating to the intended transportation, including cancellation or delay of a flight or the failure to provide a return flight, irrespective of cause.

I, on behalf of myself and the Minors/Other Individual(s), if applicable, do hereby grant permission to Aviation Angels of Hope, Inc to use my/our name and visual image in any marketing publications which might appear in the various media, or in connection with public relations activities of Aviation Angels of Hope, Inc. I hereby confirm that I have carefully read and understand this agreement, that it is a Release of potential claims of liability for the negligence of Aviation Angels of Hope, Inc., the Pilot(s), aircraft owner(s), or other volunteers by me on behalf of myself and any Minor/Other Individual unable to provide his/her own consent) for whom I am responsible, and that I am signing it of my own free will.

Adult Passenger (18 years or older) on behalf of myself:

Print Name: _____ Signature: _____ Date: _____

Address:_____

Emergency Contact: _____ Emergency Contact Phone :_____

Second Adult Passenger, (18 years or older) on behalf of myself (if applicable):

Print Name: _____ Signature: _____ Date:_____

Address:_____

Emergency Contact: _____Emergency Contact Phone:_____

Parent, Legal Guardian or other Person Authorized to Sign for Minor/Other Individual(s) below (Proof of guardianship may be required):

Print Name: _____ Signature: _____ Date: _____

Address:_____

Nature of Relationship: Parent___; Sole Guardianship___; Shared Guardianship____, with_____

Other (explain)_____

Emergency Contact: _____ Emergency Contact Phone :_____

Minor (less than 18 years old/Other Individual) or other individual unable to give consent:

Print Name: _____ Emergency Contact: _____

Address: _____Emergency Contact Phone :_____

Minor (less than 18 years old/Other Individual) or other individual unable to give consent:

Print Name: _____ Emergency Contact: _____

Address: _____ Emergency Contact Phone :_____

Aviation Angels of Hope, Inc.
Phone: 888-610-5510
Fax: 800-794-7719

Aviation Angels of Hope, Inc.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are This Notice describes the privacy practices of Aviation Angels of Hope, Inc. It applies to your medical information, including your medical record for all services provided to you and by our volunteer pilots.

II. Our Privacy Obligations We are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Flight Operations.

B. We may use and disclose PHI, but not your "Highly Confidential Information" (defined in Section IV.C below), in order to transport you, obtain linked services with other similar organizations, as detailed below: Transport. We use and disclose your PHI to provide appropriate volunteer pilot referral. and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide logistical reminders or information about transport alternatives. We may also disclose PHI to other transportation providers involved in your trip. Transportation Co-ordination. We may use and disclose your PHI for our transport care referral operations, which include internal administration and planning and various activities that improve the quality and effectiveness of the assistance that we arrange for to you. For example, we may use PHI to evaluate the quality of our operations. We may also disclose PHI to your other volunteer pilots when such PHI is required for them to appropriately help you. Disclosure to Relatives, Close Friends and Other Caregivers.

C. We may use or disclose your PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclosure your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death. Fundraising Communications.

D. We may contact you to request permission to use elements of your trip in connection with public relations, outreach, development, and educational aspects of Lifeline's operations. Judicial and Administrative Proceedings

E. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process. Law Enforcement Officials

F. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. Decedents.

G. We may disclose your PHI to a coroner or medical examiner as authorized by law. Organ and Tissue Procurement

H. We may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety. Specialized Government Functions.

J. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances. As required by law

IV. Uses and Disclosures Requiring Your Written Authorization . We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

A. Use or Disclosure with Your Authorization

B. For any purpose other than the ones described above in Section III, we only may use or disclose your PHI when you grant us your written authorization on our authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and Illinois law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental

disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or (9) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints

B. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director. Right to Request Additional Restrictions

C. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please request so in writing. We will send you a written response. Right to Receive Confidential Communications

D. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations. Right to Revoke Your Authorization

F. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below. Right to Amend Your Records

G. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please submit such a request in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply. In the case of a requested amendment concerning information about the treatment of a mental illness or developmental disability, you have the right to appeal our decision not to amend your Protected Health Information to an Illinois court. Right to Receive An Accounting of Disclosures

H. Upon request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you $0.50 per page of the accounting statement. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Release shall remain effective for a period of 90 days from the date of signature.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice.

_____, 20____

Signature of Patient (Legal or Personal Representative) Date of Signature

_____

Print Patient Name