HOSPICE PROMISE FOUNDATION

REQUEST FOR SUPPORT FORM

The Hospice Promise Foundation Board of Directors (BOD) requires the completion of this form for submission and approval of a grant request. Verbal communication with any member(s) of the BOD or their representatives shall not substitute for submission of this form. Each space must be complete.

The Hospice Promise Foundation Mission Statement

The Hospice Promise Foundation's mission is to assist persons in hospice care and their families with essential, non-hospice related expenses that they are unable to afford themselves. The Hospice Promise Foundation is a non-profit organization funded by donations from grateful patients, families and friends of our patients and is governed by the Board of Directors.

Applicant Information

Patient name: _____ Social worker or agency contact name: _____

Agency name: _____ City: _____ State: _____

If approved, payment should be made to the following vendor: _____

Physical address: _____

City: _____ State: _____ ZIP code: _____

Vendor phone number: _____ Vendor email: _____

Description of Request

* If requesting utility or any payments for which there is an account and account number, please attach documentation indicating the account holder's name and account number. In some circumstances, the account holder's SSN may be requested by the HPF in order to apply the grant payment to the proper account.

($500 cap per patient)

❑ Rent ❑ Utilities ❑ Emergency Repair ❑ Food Assistance ❑ Comfort Care/Personal ❑ Last Wishes

Requested amount: $ _____ Explanation: _____

_____

❑ Burial/cremation ($700 cap per patient) Requested amount: $ _____ Has the patient passed away? ❑ Yes ❑ No Date of death: _____

Explanation: _____

_____

Required Additional Documentation *must be attached to grant request forms

❑ Charity care form attached ❑ Supporting financial documentation attached

Procedure for Completed Application

All completed Request for Foundation Support Forms should be accompanied by a Financial Needs Assessment Form and are subject to limits established by the Foundation guidelines. Requests will be sent to The Hospice Promise Foundation Board for review. A representative of the Foundation will contact you within 72 hours of receipt. If request for funds is emergent, an answer will be sent within 24 hours of receipt. The Foundation, as a non-profit entity, may require a follow-up report to verify the donation was spent in accordance with this request. Please designate the individual(s) responsible for submitting a follow-up report and supplying the requested information.

Print name of agency submitter: _____ Date: _____

Submitter phone number: _____ Submitter Email: _____

Email this form to **Hospice.Foundation@LHCgroup.com** or send to: **The Hospice Promise Foundation**, 901 Hugh Wallis Rd S, Lafayette, LA 70508

Applicant Information

Date received: _____ **Date approved:** _____

Approved by: _____ **Date submitted for processing:** _____

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FINANCIAL NEEDS ASSESSMENT FORM

Date: _____ Name of Grant Recipient: _____

Please provide any of the following items that are applicable in order to confirm grant recipient's household monthly income/Reserves:

- ❑ Most recent Federal / State income tax forms
- ❑ Unemployment check stubs/paycheck (3mths)
- ❑ Statement of monthly benefits from SS
- ❑ Life insurance policy documentation
- ❑ Documentation of other investment accounts
- ❑ W-2 withholding statements and/or 1099
- ❑ Copy of proof of pension amount
- ❑ Approval/Denial forms of public aid, unemployment, and worker's compensation
- ❑ 401k/Retirement account balance
- ❑ Regular savings and/or checking acct balance

STATED/CONFIRMED GRANT RECIPIENT'S MONTHLY INCOME: _____

STATED/CONFIRMED GRANT RECIPIENT'S RESERVES VALUE: _____

Based on grant recipient's income and applicable family or household size, please circle the current number of individuals living in the household.

TOTAL PERSONS IN FAMILY OR HOUSEHOLD				
Monthly Income	**1**	**2**	**3**	**4**
Less than / equal to	**$2,082**	**$2,818**	**$3,555**	**$4,292**
Monthly Income	**5**	**6**	**7**	**8 or >**
Less than / equal to	**$5,028**	**$5,765**	**$6,502**	**$7,138**

Add $368 for each person over 8

PATIENT ATTESTATION: This is to advise that I have pursued all other avenues possible, including private insurance, governmental and charitable agencies providing funding and relief from financial obligations as well as public aid. Therefore, I hereby request that The Hospice Promise Foundation make a determination of my eligibility for grant assitance. I understand that the information, which I submit concerning my annual income, family size and asset reserves, is subject to verification by The Hospice Promise Foundation.

Name: _____ DOB: _____
(Patient/Patient's Responsible Party)

Street Address: _____
(Patient/Patient's Responsible Party) City State

Telephone: _____ Marital Status: _____ # of Dependents: _____ Ages: _____

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