

The 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 donation 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 Foundation may also provide funding for community support projects such as Bereavement Camps for Children or Educational Outreach Programs for end-of-life care. The Hospice Promise Foundation is a non-profit organization funded by donations from grateful families and friends of our patients and is governed by the Board of Directors.

Applicant Information

Agency name: _____ City: _____ State: _____

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

If approved, payment should be made to: _____

Address where check should be mailed: _____

City: _____ State: _____ ZIP code: _____

Phone number: _____ Email: _____

Description of Request

RENT OR EMERGENCY REPAIRS

Requested amount: \$ _____
(\$600 cap)

Explanation: _____

UTILITY BILLS

Requested amount: \$ _____
(\$600 cap)

Explanation: _____

FOOD ASSISTANCE

Requested amount: \$ _____
(\$600 cap)

Explanation: _____

COMFORT CARE PERSONAL ITEMS

Requested amount: \$ _____
(\$600 cap)

Explanation: _____

LAST WISHES

Requested amount: \$ _____
(\$600 cap)

Explanation: _____

BURIAL ASSISTANCE

Requested amount: \$ _____
(\$900 cap)

Explanation: _____

Required Additional Documentation

Charity care form attached

Supporting documentation attached

Procedure for Completed Application

All completed Request for Foundation Support Forms should be accompanied by a Charity Form and are subject to limits established by the Foundation guidelines. Requests will be sent to The Hospice Promise Foundation 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, requires 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.

Name: _____ Phone: _____ Email: _____

Signature of requestor: _____ Date: _____

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: _____



CHARITY CARE FORM

DATE: _____ PATIENT NAME: _____ MR#: _____

Please provide any of the following items that are applicable in order to confirm family monthly income/Reserves:

- | | |
|--|---|
| <input type="checkbox"/> Most recent Federal / State income tax forms | <input type="checkbox"/> W-2 withholding statements and/or 1099 |
| <input type="checkbox"/> Unemployment check stubs/paycheck (3mths) | <input type="checkbox"/> Copy of proof of pension amount |
| <input type="checkbox"/> Statement of monthly benefits from SS | <input type="checkbox"/> Approval/Denial forms of pub aid, unemp, WC |
| <input type="checkbox"/> Life insurance policy documentation | <input type="checkbox"/> 401k/Retirement account balance |
| <input type="checkbox"/> Documentation of other investment accounts | <input type="checkbox"/> Regular savings and/or checking acct balance |
| <input type="checkbox"/> Documentation/statement of other assests/estate | |

STATED/CONFIRMED MONTHLY INCOME: STATED/CONFIRMED RESERVES VALUE:

Please provide the details of current or expected financial concerns:

Based on family income and applicable family or household size, please circle current number of members living in the household.

Monthly Income	TOTAL PERSONS IN FAMILY OR HOUSEHOLD				DISCOUNT
	1	2	3	4	
Less than / equal to	\$1,944	\$2,620	\$3,298	\$3,974	100%
Monthly Income	5	6	7	8 or >	DISCOUNT
Less than / equal to	\$4,650	\$5,328	\$6,004	\$6,680	100%

Please indicate total family reserves (Life insurance value, 401k, Retirement accounts, savings, other investments)

Total Reserves	TOTAL PERSONS IN FAMILY OR HOUSEHOLD				DISCOUNT
	1	2	3	4	
Less than / equal to	\$50,000	\$67,500	\$91,125	\$123,019	100%
Total Reserves	5	6	7	8 or >	DISCOUNT
Less than / equal to	\$166,075	\$224,202	\$302,672	\$408,608	100%

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 LHC Group Inc. make a determination of my eligibility for (Home Health / Hospice / Hospital) services on a reduced fee basis. I understand that the information, which I submit concerning my annual income, family size and asset reserves, is subject to verification by LHC Group Inc.

Name: _____ DOB: _____ SSN: _____
(Patient)

Name: _____ DOB: _____ SSN: _____
(Guarantor / Responsible Party)

Street Address: _____
(Guarantor) City State Zip

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