# 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: $_____ ($400 cap)
Explanation: _____

❑ UTILITY BILLS
Requested amount: $_____ ($400 cap)
Explanation: _____

❑ FOOD ASSISTANCE
Requested amount: $_____ ($400 cap)
Explanation: _____

❑ COMFORT CARE PERSONAL ITEMS
Requested amount: $_____ ($400 cap)
Explanation: _____

❑ LAST WISHES
Requested amount: $_____ ($400 cap)
Explanation: _____

❑ BURIAL ASSISTANCE
Requested amount: $_____ ($700 cap)
Explanation: _____
Has the patient passed away? ❑ Yes ❑ No

## 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 Financial Needs Assessment 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:** _____

HOSPICE PROMISE FOUNDATION

# 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:**

- ☐ 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
- ☐ Documentation/statement of other assests/estate
- ☐ W-2 withholding statements and/or 1099
- ☐ Copy of proof of pension amount
- ☐ Approval/Denial forms of pub aid, unemp, WC
- ☐ 401k/Retirement account balance
- ☐ Regular savings and/or checking acct balance

**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.**

| | TOTAL PERSONS IN FAMILY OR HOUSEHOLD | | | | |
|---|---|---|---|---|---|
| **Monthly Income** | 1 | 2 | 3 | 4 | **DISCOUNT** |
| 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 PERSONS IN FAMILY OR HOUSEHOLD | | | | |
|---|---|---|---|---|---|
| **Total Reserves** | 1 | 2 | 3 | 4 | **DISCOUNT** |
| 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: _____