FOUNDATION
FOR END - OF - LIFE - CARE

FFEOLC USE ONLY
Case# _____AMOUNT GRANTED:_____
□ CK# _____□BC _____
Date: _____ □ APR. □DNF_____

DATE: _____
NAME OF HOSPICE: _____ TELEPHONE:_____
ADDRESS OF HOSPICE: _____

PLEASE PRINT CLEARLY:

PATIENT NAME:_____

PATIENT ADDRESS:_____

HOSPICE ADMISSION DATE: _____ AGE: _____ D/C DATE (IF APPLICABLE):_____

NAME OF PRIMARY CAREGIVER: _____ RELATIONSHIP TO PATIENT: _____

PRIMARY CAREGIVER PHONE: _____

PRIMARY CAREGIVER ADDRESS: _____

PLEASE PROVIDE US WITH A DETAILED EXPLANATION OF THE CIRCUMSTANCES OF THIS PATIENT/FAMILY SITUATION THAT FULFILLS THE SPECIAL NEEDS CRITERIA: (PRINT OR ATTACH A TYPED STATEMENT). YOU MUST ALSO ATTACH THE PURCHASE ORDER/BILL THAT YOU ARE REQUESTING ASSISTANCE TO PAY.

_____

_____

_____

_____

_____

□ CHECK HERE IF COMMUNITY RESOURCE FUNDS ARE NOT AVAILABLE AT THE TIME OF THIS APPLICATION.
□ CHECK HERE IF YOU ARE AUTHORIZED TO RELEASE PRATIENT INFORMATION (HIPAA REQUIREMENT).

TOTAL AMOUNT REQUESTED: _____ FOR _____ (RENT, UTILITY, FOOD, ETC.)

SIGNATURE OF SENIOR STAFF PERSONNEL: _____PHONE: _____
(VP, GM, PCA)

SIGNATURE OF TEAM MANAGER: _____PHONE:_____

SIGNATURE OF AUTHORIZED STAFF MAKING THIS REQUEST: _____PHONE: _____

THE FOUNDATION FOR END-OF-LIFE CARE RESERVES THE RIGHT TO ACKNOWLEDGE AND GIVE SPECIFIC MENTION TO YOUR HOSPICE ON OUR WEBSITE AS A REQUESTOR & RECIPIENT OF OUR FINANCIAL SUPPORT FOR THE HOSPICE PATIENTS YOU SERVE. YOU ARE ACKNOWLEDGING THIS BY SIGNING OFF ON THIS REQUEST FOR FUNDS AS AN AUTHORIZED REPRESENTATIVE OF YOUR HOSPICE PROGRAM.

FOR FOUNDATION STAFF USE ONLY

COMMENTS:_____

SIGNATURE OF FFEOLC AUTHORIZED STAFF: _____

SEND THIS FORM VIA EMAIL SCAN TO ADMINISTRATION@FOUNDATIONEOLC.ORG

FOUNDATION
FOR END - OF - LIFE - CARE

SPECIAL NEEDS FINANCIAL ASSESSMENT WORKSHEET

PATIENT NAME: _____ CAREGIVER NAME:_____

NOTE: IF THE PATIENT IS ON MEDICAID/MEDICAL OR A CHARITY PATIENT, THE FINANCIAL ASSESSMENT FOLLOWING IS FOR THE SPOUSE/OTHER FAMILY MEMBERS WHO HAVE INCOME AND WHO ARE RESIDING AT THE SAME ADDRESS AS THE PATIENT.

MEDICAID/MEDICAL #_____CHARITY PATIENT: _____

IF TRANSPORATION IS BEING REQUESTED, A FINANCIAL REVIEW MUST BE COMPLETED ON THE INDIVIDUAL REQUESTING TRAVEL ASSISTANCE. NAME OF PERSON REQUESTING TRAVEL ASSISTANCE: _____

OF INDIVIDUALS RESIDING WITH PATIENT: ADULT(S): _____ CHILD(REN):_____

OF EMPLOYED INDIVIDUALS RESIDING WITH PATIENT: _____ OWN HOME: _____ RENT HOME: _____

I.	**MONTHLY INCOME**	PATIENT	SPOUSE/OTHER
	GROSS WAGES FROM EMPLOYMENT	$ _____	$ _____
	SOCIAL SECURITY: TYPE _____	$ _____	$ _____
	PENSION(S)	$ _____	$ _____
	OTHER INCOME: TYPE _____	$ _____	$ _____
	LOANS/CONTRIBUTIONS FROM AGENCIES/FAMILY/FRIENDS	$ _____	$ _____
	TOTAL INCOME:	$ _____	$ _____

II.	**MONTHLY FINANCIAL OBLIGATIONS**	**PATIENT**	**SPOUSE/OTHER**
	MORTGAGE/RENT	$ _____	$ _____
	ELECTRIC	$ _____	$ _____
	WATER	$ _____	$ _____
	PHONE	$ _____	$ _____
	CREDIT CARD(S) MONTHLY PAYMENTS	$ _____	$ _____
	HEATING OIL	$ _____	$ _____
	INSURANCE POLICIES	$ _____	$ _____
	MEDICINE	$ _____	$ _____
	FOOD	$ _____	$ _____
	CAR PAYMENT	$ _____	$ _____
	OTHER:	$ _____	$ _____
	TOTAL MONTHLY EXPENSES	$ _____	$ _____

SEND THIS FORM VIA EMAIL SCAN TO ADMINISTRATION@FOUNDATIONEOLC.ORG