Assisted Home Health & Hospice Foundation

Hands to Help, Hearts to Care®

Special Needs Grant Request

non-profit 501(c)(3) organization

Date: _____

Requestor Information

Name: _____

Job Title: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Recipient Information

Patient's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Fax: _____

Name of Hospice: _____

Hospice Admission Date : _____ Age: _____ Patient's Gender: ☐ M ☐ F

Name of Primary Caregiver: _____

Phone Number and Address of Primary Caregiver: _____

Diagnosis: _____

Special Need Information

Need identification: ☐ Cremation Assistance ☐ Caregiver ☐ % of cost for care (up to $1,000)
☐ Transportation ☐ Other: _____

Please describe in detail the patient's UNIQUE circumstances and specific need(s) that fulfill the special needs criteria. Please print clearly:

_____

_____

_____

_____

_____

Please state exactly what item(s) will be purchased and/or what services will be provided if this gift is given:

_____

_____

_____

_____

_____

Special Need Information

Patients Name: _____ Medical Record #: _____

If the patient is on Medicare/MediCal, please record their number here: _____

Number of employed individuals in household: _____ Do you own your home: _____

Total Assets	**Patient**	**Spouse/other**
Name of Bank:	$	$
Checking Account	$	$
Savings Account	$	$
Funeral/Burial Pre-arrangements	$	$
TOTAL ASSETS	$	$

Total Monthly Income	**Patient**	**Spouse/other**
Gross Wages	$	$
Social Security	$	$
Pensions	$	$
Interest Income	$	$
Loans / Contributions from Agencies or Family/Friends	$	$
TOTAL INCOME	$	$

Total Monthly Expenses	**Patient**	**Spouse/other**
Mortgage or Rent	$	$
Utilities	$	$
Credit Cards or Other Credit (Monthly Payment)	$	$
Insurance Payment	$	$
Medicine	$	$
Food	$	$
Car Payment	$	$
Other	$	$
TOTAL MONTHLY EXPENSES	$	$

Net Monthly Income	**Patient**	**Spouse/other**
Total Monthly Income	$	$
Total Monthly Expense	$	$
NET MONTHLY INCOME	$	$

Special Need Information Agreement

☐ Check here if funds from community resources are not available at this time.

☐ Check here if you have authorization to release patient information (HIPAA Requirements)

Total amount requested_____ for _____

I certify that the above-named patient is currently receiving hospice care, and cannot provide the time or service requested from his/her own funds, or from his/her immediate family's funds, without suffering undue financial hardship. I certify that all of the above information is true and complete.

Requestor Signature _____ Date _____

Signature of Director of Patient Care Services

_____ Date _____

Signature of Branch Manager _____ Date _____

The recipient of funds from Assisted Home Health & Hospice Foundation agrees to comply with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA") and any current and future regulations promulgated thereunder including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Part 142 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained n 45 C.F.R. Parts 160 and 162, all collectively referred to herein as "HIPAA Requirements."

The recipient agrees not to use or further disclose any Protected Health Information (as defined in 45 C.F.R. Section 164.501) or Individually Identifiable Health Information (as defined in 42 U.S.C. Section 1320d), other than as permitted by HIPAA Requirements and the terms of this Agreement.

Patient Signature _____ Date_____

For foundation use only:

☐ Approved ☐ Denied

Reason (s) / Plan Distribution

_____

_____

_____

Foundation Executive Director Signature _____ Date_____