



HOSPICE & PALLIATIVE  
CARE FOUNDATION

\_\_\_\_\_  
(Name of Hospice Agency)

\_\_\_\_\_  
(Street Address of Hospice Agency)

\_\_\_\_\_  
(City, State, and Zip Code of Hospice Agency)

Date: \_\_\_\_\_

RE: \_\_\_\_\_

This letter is to certify that \_\_\_\_\_ is a current \_\_\_\_\_  
(Patient's First and Last Name) (Type of Service)

patient with the \_\_\_\_\_. They have been on our service since  
(Name of Hospice Agency)

\_\_\_\_\_.  
(Date Service Started)

Thank you in advance for your time and review of this relief fund application.

Sincerely,

\_\_\_\_\_  
(Hospice Team Member's Signature)

\_\_\_\_\_  
(Hospice Team Member's Printed Name)

Phone: \_\_\_\_\_  
(Hospice Team Member's Contact)

Email: \_\_\_\_\_  
(Hospice Team Member's Email)