



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)