HOSPICE & PALLIATIVE CARE FOUNDATION

Adult HPCF Fund
Relief Fund Request Form

****PLEASE PRINT CLEARLY & LEGIBLY – APPLICATIONS THAT ARE NOT CLEAR WILL BE RETURNED****

The Hospice & Palliative Care Foundation's *Relief Fund* is designed to help adult patients with items such as their rent, mortgage, electric utility, gas utility, water utility, and/or sewer utility expenses.

The *Relief Fund* can also be used to (a) obtain certain equipment needed for everyday living or (b) help with a deceased adult patient's funeral costs. **The maximum relief fund that can be awarded under this category is $500.00**. Note: our relief funds **cannot** be used for cable service, internet service, mobile phone service, or landline phone service. Relief funds are paid directly to the patient's service provider and **cannot** be sent directly to the patient, caregiver, or legal guardian (s).

Adult patients receiving relief funds must meet **ALL** the guidelines listed below:

1. The applicant (or deceased patient) must be an adult (age twenty-one or older).
2. The applicant (or deceased patient) must be a resident of South Carolina.
3. The applicant (or deceased patient) must currently be on hospice or palliative care services. For funeral relief fund requests, the deceased patient must have been on hospice or palliative care services at the time of their passing.

Patient Information – Please Complete All Sections:

Patient's Name (First and Last Name): _____

Patient's Date of Birth: _____ Is/was the patient a veteran or spouse of a veteran? _____

Patient's Physical Address: (*Not a Post Office Box*):

_____ _____
Street (Do Not Forget Extension i.e. Road, Street) City

_____ _____ _____
State Zip Code Adult Patient's County

Adult Patient's Gender: _____ Adult Patient's Ethnicity: _____

Vendor Information Section – Please Complete All Sections:

Name of Vendor Being Paid: _____ _____
Account or Reference Number

Vendor's Address: _____ _____

Street (Do Not Forget Extension i.e. Road, Street) City

_____ _____ _____

State Zip Code Phone

Amount Being Requested: _____

In addition to the above information, please submit the following items along with this request form. **ALL** items are required to approve a relief fund request. *Please note that while the majority of our patients will only need to provide the items below, applications are reviewed on a per patient basis. Based on the type of request, additional documentation may be needed in order to approve an application. Our website contains a more detailed list of potential items that may be required at https://www.hpcfoundation.org/need-and-assistance-fund.*

1. Verification letter signed by the patient's social worker typed on company letter head identifying the dates of service and include the social worker's name, title, phone number, and email address. If the social worker does not have access to company letterhead, they complete the *HPCF Verification Form*, which can be found on our website at *https://www.hpcfoundation.org/need-and-assistance-fund.* No substitutions allowed.
2. A legible and readable copy of the bill or invoice. The bill or invoice **must be itemized** showing all charges, discounts, payments, and expected payments. The bill or invoice must be within thirty (30) days of these forms being signed. We must receive ALL of the pages for the bill or invoice. We will be unable to continue the application review process or approve an application if all of the pages are not received. *Note: The bill or invoice must be in the adult patient's name for which the relief fund is being awarded.*

Other Requirements (Where Applicable):

If the patient is requesting relief funds to help pay for equipment/item needed for everyday living (i.e. ramp, wheelchair), the patient must pay the amount due over the maximum relief fund before we can process the final relief fund payment. Proof of payment will be required in addition to the other supporting documentation before any relief funds are awarded. Depending on type of vendor being paid, a *Form W9* may be required from the vendor before any award payment is submitted for processing.

If a patient is requesting relief funds to help pay for goods or services that *may be* covered by a medical/dental/vision insurance plan, the patient must obtain a *Pre-Treatment Estimate Explanation of Benefits* prior to submitting an application in order to determine the award amount. In lieu of a *Pre-Treatment Estimate Explanation of Benefits,* the patient can provide their processed *Explanation of Benefits* claim showing the breakdown of what the insurance company has paid and the patient's responsibility. This is in addition to the detailed invoice described earlier.

If the family or caregiver of a deceased patient is requesting relief funds toward funeral costs, the billing statement or invoice **must be itemized** to show all charges and any discounts being given by the funeral home itself. In addition to listing payments being applied to the deceased's account (e.g. life insurance), the funeral home director should make note of any other payments being applied to the billing statement or invoice, even if they have not yet been received. Billing statements and invoices must be signed by the funeral home director.

DISCLOSURE STATEMENTS – PLEASE READ CAREFULLY BEFORE CONTINUING AND SIGNING:

As a public nonprofit, 501(c)(3), organization, we cannot provide gifts, awards, and/or relief funds to individuals that are not a United States Citizen. Accordingly, individuals receiving gifts, awards, and/or relief funds that are

funded by *The Hospice & Palliative Care Foundation* must either be a United States Citizen or a Naturalized United States Citizen.

By signing below, the patient agrees to the foregoing disclosures and is attesting they are a United States Citizen or a Naturalized United States Citizen. Individuals that provide false information in the foregoing sections or is found not be a United States Citizen or a Naturalized United States Citizen may be subject to criminal and/or civil penalties based on the laws of South Carolina. In addition, if the patient received assistance completing this application from a responsible party (see below) or from a member of their healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on their behalf.

Patient's Signature: _____ Date: _____
If the patient is unable to sign or if deceased, **STOP, **DO NOT SIGN THIS SECTION,** the person completing the request (not the hospice team member) will need to provide the following for informational purposes only.*

If the responsible party received assistance completing this application on behalf of the patient by a member of the patient's healthcare team, by signing below, they agree they have reviewed and confirm the accuracy of the information completed on the patient's behalf.

Responsible Party's Signature: _____Date: _____

Name of Responsible Party Completing Forms: _____

Address of Responsible Party Completing Forms:

_____ _____
Street (Do Not Forget Extension i.e. Road, Street) City

_____ _____ _____
State Zip Code Phone

Email: _____

Relationship to Patient: _____

Hospice Team Member Please Sign Below In The Box:

For Administration and Accounting Use Only:

Level One (Hospice Worker):_____**Date:**_____

Level Two Approver (Associate Director):_____**Date:**_____

Level Three Approver (Accounting):_____**Date:** _____