HOSPICE & PALLIATIVE CARE FOUNDATION

Pediatric 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 the parent (s) or legal guardian (s) caring for pediatric patients with 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 a deceased pediatric patient's family with 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's parent (s) or legal guardian (s).

Pediatric patients receiving relief funds listed above must meet **ALL** of the guidelines listed below:

1. The pediatric patient receiving the benefit of awarded relief funds must be twenty-one (21) years of age or younger.
2. The pediatric patient receiving the benefit of awarded relief funds must be a resident of South Carolina. If the pediatric patient is deceased, they must have been a resident of South Carolina at the time of their passing.
3. The pediatric patient receiving the benefit of awarded relief funds must currently be on hospice or palliative care services. For those applying for a funeral relief fund, the deceased pediatric 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 child 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 Pediatric Patient's County

Pediatric Patient's Gender: _____ Pediatric Patient's Ethnicity: _____

Parent (s) / Legal Guardian (s) Information – Please Complete All Sections:
**This section does not need to be completed if the pediatric patient is over the age of eighteen (18) and is legally competent to sign on their behalf.*

Parent (s) / Legal Guardian (s) Name (First and Last Name): _____

Parent (s) / Legal Guardian (s) Physical Address: (*Not a Post Office Box*):

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

_____ _____ _____
State Zip Code Phone Number / Email Address

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/pediatric-care-program.*

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 can complete the *HPCF Verification Form,* which can be found on our website at https://www.hpcfoundation.org/pediatric-care-program.
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 patient's name or be related to the patient's primary residence for which the relief fund is being awarded.*

Other Requirements (Where Applicable):

If the parent (s) / legal guardian (s) are requesting relief funds to help pay for equipment/item needed for everyday living (i.e. ramp, wheelchair), the parent (s) / legal guardian (s) 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 parent (s) / legal guardian (s) of a deceased patient are 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:

Individuals requesting gifts and relief funds on behalf of a minor patient must be the patient's parent (s) or legal guardian (s). We cannot accept requests from family members or friends unless they have been granted legal guardianship by a family court judge.

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 parent (s) / legal guardian (s) agrees to the foregoing disclosures. They are attesting that they are the patient's parent (s) or legal guardian (s). They are attesting that their minor child (under the age of eighteen) is a United States Citizen or a Naturalized United States Citizen. Individuals that provide false information in the foregoing sections, or is found not be the patient's parent (s) or legal guardian (s), or the patient is found not to 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.

If the parent (or legal guardian) or the patient 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.

Parent / Legal Guardian Signature:_____ Date: _____
Note: if the pediatric patient is over the age of eighteen (18) **and is legally competent to sign on their behalf, **STOP, DO NOT SIGN HERE,** they will sign below.*

Patient Signature: _____ Date: _____

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:** _____