HARBOR | FOUNDATION

Request for Financial Assistance

Date: _____ HospiceName: _____

Address:_____Telephone: _____

Patient's Name: _____ Address: _____

_____

HospiceAdmissionDate:_____D/CorDODif Applicable:_____

Name of Primary Caregiver: _____ Relationship: _____

Address of Primary Caregiver: _____

Telephone Number of Primary Caregiver: _____

Please give detailed explanation of the unique circumstances of this situation that fulfill the special needs criteria: (Please print or attach a typed statement) _____

_____

_____

_____

_____

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

☐ Check here if you have Authorization to Release Patient Information (HIPAA Requirement).

Total amount requested:* _____ for _____

(funeral expenses, rent, utilities, food, etc.). Check made payable to: _____

Address/City/State/Zip/Phone: _____

*An invoice or purchase order must accompany this request.

Name of person recommending this request: _____ Title: _____

Signature: _____ Telephone: _____

Signature of Administrator: _____ Telephone: _____

For Foundation/Accounting Staff Only

☐ Request Granted ☐ Request Denied Request ☐ Granted as Modified

Comments: _____

_____

_____

Authorized Signature: _____ Date: _____

Printed Name: _____ Title: _____

Check #: _____ Date: _____

Check Given/Mailed to: _____ Date: _____