

## GRANT APPLICATION FORM - FUNERAL/MEMORIAL SERVICE ASSISTANCE

**IMPORTANT: Please read before completing your application.**

This application form may be used to request assistance from Hospice Support Foundation (HSF) for grant awards to be used toward the funeral or memorial service expenses for an individual who is currently in hospice care and is a Medicaid recipient or who passed away while in hospice care and was a Medicaid recipient at the time of passing and who is/was cared for in the Midwestern states described on our website.

Grant awards are based on current household income and assets and are available for Medicaid recipients only. Award amounts are based on direct cremation costs in one's state. Funeral assistance grants awarded are not exclusive to cremation - they may be put towards burial costs should cremation not be desired. **Assistance must first be sought out from other sources, such as County, State or VA before applying to HSF.** HSF pays funeral homes/vendors directly and cannot make payments to individuals. HSF is unable to provide assistance if the funeral home/vendor costs have been paid in full.

*Please note - this form can be completed electronically using a computer. It cannot be completed electronically with a cell phone at this time. It may or may not be compatible with other devices. This form can be printed, completed by hand, scanned and emailed. If a scanner is unavailable, pictures of individual pages may be emailed **in one email** as noted on the last page in Submission Instructions. Please ensure all information is visible in the pictures to avoid significant delays.*

Please refer to the last page of the application for instructions on how to submit the application as well as the anticipated timeline for review.

## GRANT APPLICATION FORM - FUNERAL/MEMORIAL SERVICE ASSISTANCE

### APPLICANT INFORMATION

1. Name of hospice patient/decedent for whom funeral arrangements are being made ("Applicant"):

1.a. Is the hospice patient/decedent named above a Medicaid recipient at present or was a Medicaid recipient at the time of their passing?

☐ Yes. Please attach documented proof that the individual in question 1 is/was a Medicaid recipient at the time of applying/passing and continue completing the application in full, including the financial information page.

☐ No. Please STOP here. The hospice patient/decedent is not eligible for funeral assistance.

2. In what county and state does the individual named in question 1 above reside?

County

State

3. For the individual named in question 1 above, what is/was their affiliation with hospice? Please also provide the hospice provider's information.

☐ Currently enrolled in hospice care

☐ Deceased while in hospice care

Date of Death:

Hospice Provider Organization Name

Hospice Provider Phone

Street Address

City

State

Zip Code

4. Please provide an address where an application notification letter can be sent:

Name

Street

City

State

Zip Code

Phone number

Email address

5. If you are an employee of a hospice organization and are completing or assisting with this request for the individual receiving funeral arrangements, please provide the following information:

Employee Name

Job Title

Direct Phone Number

Branch Location

# APPLICANT FINANCIAL INFORMATION

**Please provide the financial information of the hospice patient/decedent below .**

*Reasonable, good faith estimates are acceptable in this section.*

6. Is the hospice patient/decedent for whom funeral arrangements are being made: ☐ married ☐ single

***If married, please provide joint financial information.***

7. Number in household:

Monthly Household Income:		Personal Assets:	
Wages (after taxes):	<input type="text"/>	Cash, Checking, Savings, Stocks, Bonds:	<input type="text"/>
Interest/Investment Income:	<input type="text"/>	Retirement Savings:	<input type="text"/>
Social Security/Pension Income:	<input type="text"/>	Home Equity (amount paid off on home):	<input type="text"/>
Other Income:	<input type="text"/>	Automobile(s) Value:	<input type="text"/>
	<input type="text"/>	Other Assets:	<input type="text"/>
<b>Total Monthly Income:</b>	<input type="text"/>	<b>Total Assets:</b>	<input type="text"/>
Monthly Household Expenses:		Personal Liabilities:	
Mortgage/Rent:	<input type="text"/>	Home Loan Debt (amount still owed):	<input type="text"/>
Property Taxes:	<input type="text"/>	Automobile Loan (amount still owed):	<input type="text"/>
Homeowners/Renters Insurance:	<input type="text"/>	Credit Card Debt:	<input type="text"/>
Utilities (Electric/gas/phone/water):	<input type="text"/>	Other Debt:	<input type="text"/>
Cable TV/Cell Phone:	<input type="text"/>		<input type="text"/>
Car Insurance:	<input type="text"/>		<input type="text"/>
Transportation:	<input type="text"/>		<input type="text"/>
Groceries:	<input type="text"/>		<input type="text"/>
Medical Insurance:	<input type="text"/>		<input type="text"/>
Personal (clothing, hair care, etc.):	<input type="text"/>		<input type="text"/>
Child Care:	<input type="text"/>		<input type="text"/>
Credit Cards:	<input type="text"/>		<input type="text"/>
Other Expenses:	<input type="text"/>		<input type="text"/>
<b>Total Monthly Expenses:</b>	<input type="text"/>	<b>Total Liabilities:</b>	<input type="text"/>

## GENERAL INFORMATION

8. Please tell us how much you are requesting: \$

9. Is payment required before the funeral home will pick up the decedent **from the place of death**?

☐

Yes - if yes, please call us immediately at 651-294-6100

☐

No

10. Please tell us more about why this assistance is being requested:

11. Please itemize below the cost of the funeral arrangements. **Required: Please attach a copy of the estimate (if patient is still living at the time of submission) or invoice (if the patient has passed away) from the funeral home.**

**CONTINUED FROM PREVIOUS PAGE....**

**Reminder: funeral/burial assistance must be sought out from the State/County/VA first before applying to the HSF.**

12. Does the hospice patient/decedent have a preneed funeral contract, funeral trust or funeral insurance?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much?	\$ <input type="text"/>
13. Does the hospice patient/decedent have life insurance that will help pay a portion of the expenses?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much?	\$ <input type="text"/>
14. Has State/County burial/funeral assistance been applied for?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
15. If State/County burial/funeral assistance has not been applied for, please tell us why.	<input type="text"/>			
16. Has State/County burial/funeral assistance been awarded?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much?	\$ <input type="text"/>
17. Has the VA been contacted for burial/funeral assistance?	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
18. Has VA burial/funeral assistance been awarded?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how much?	\$ <input type="text"/>

**19. Required: If any of the above burial/funeral assistances were denied, explain why.**

**FUNERAL HOME INFORMATION**

*If approved, payment should be made to the following vendor:*

Funeral Home Name			
<input type="text"/>			
Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Contact Name	Contact Phone		
<input type="text"/>	<input type="text"/>		
Funeral Home Email Address			
<input type="text"/>			

**Signature and Consent (Please note: Typed in or electronic signatures are not accepted.)**

20. Are you the hospice patient/deceased for whom funeral arrangements are being made (read all choices before answering)?

<input type="checkbox"/> Yes. Please sign below.	<input type="checkbox"/> No, but I have <b>financial</b> power of attorney (FPOA) for the individual named in question 1. on this form. <i>Please attach FPOA form and sign below as attorney-in-fact.</i>
<input type="checkbox"/> No, hospice patient unable to sign, no FPOA available. Leave signature blank.	<input type="checkbox"/> No, individual is deceased. Leave signature blank.

Applicant Signature (required):

Date:

By signing the above, I attest that the information provided in this application is complete and true to the best of my knowledge. I consent to allowing Hospice Support Foundation (HSF) to disclose my (the applicant's) name to the vendor(s) for the purpose of arranging payment should this grant request be accepted. I understand that HSF may need to provide the name of the foundation to the vendor and that by providing the name "Hospice Support Foundation", the vendor may reach the conclusion that the applicant is receiving or is affiliated with hospice care.

## SUBMISSION INSTRUCTIONS

You may submit your completed application, including any attachments, in the following ways:

**By email:** info@hospicesupportfoundation.org

**By mail:** **Hospice Support Foundation**  
1175 Centre Pointe Circle  
Mendota Heights, MN 55120

*Please note - this form can be completed electronically using a computer. It cannot be completed electronically with a cell phone at this time. It may or may not be compatible with other devices. This form can be printed, completed by hand, scanned and emailed. If a scanner is unavailable, pictures of individual pages may be emailed **in one email** as noted above. Please ensure all information is visible in the pictures to avoid significant delays during the review of your application.*

## NOTIFICATION PROCESS

**You will be notified of the status of your pending application as follows:**

Within 10 -15 business days of submission  
Emergency Request\*: Within 72 hours of submission

*\*HSF limits its definition of an emergency funeral assistance request to the scenario where the funeral home/cremation society requires payment before they will pick up the decedent from the place of death. In this case only, please call us at 651-294-6100 and we will expedite the review of your application.*

### Notification Letter:

A notification letter will be mailed or emailed to the contact information provided in this application. Please keep this letter for your records. In some cases, it may be helpful to provide the funeral home a copy of the notification letter. Please arrange for the funeral home, a family member or a friend to contact HSF at the appropriate time to arrange for payment of the award if an approval has been granted.

Reminder: HSF pays funeral homes/vendors directly and cannot make payments to individuals. HSF is unable to provide assistance if the funeral home/vendor costs have been paid in full prior to the communication of or fulfillment of a funeral assistance grant award.

**\*\*\* For Office Use Only \*\*\***

Date Received

☐ Complete ☐ Incomplete

Missing Information/Additional Information Requested

☐ Approved \$  Amount Approved

☐ Reason for Denial

☐ Denied

Date Notification Letter Sent

☐ By Email  ☐ By Mail

Date Funeral Home Contacted for W9/Invoice/Confirm Pymt Info

☐ By Email   
☐ By Mail   
☐ W9 form ☐ Invoice Copy Received

**\*\*\* For Office Use Only \*\*\***