

This application form may be used to request assistance from the 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 or who passed away while in hospice care.

Grant awards are based on current household income and assets. 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 the County, State or VA before applying to the HSF.** The HSF pays funeral homes/vendors directly and cannot make payments to individuals.

*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 or the application will not be considered.*

### APPLICANT INFORMATION

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

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

3. For the individual named in question 1 above, what is/was their affiliation with hospice?

Currently enrolled in hospice care

Deceased while in hospice care

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:

Name:

Job Title:

Telephone:

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.***

Monthly Household Income:		Personal Assets:	
Wages (after taxes):	<input type="text"/>	Cash, 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**

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

8. 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

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

10. 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.**

- 11. Does the hospice patient/decedent have a preneed funeral contract, funeral trust or funeral insurance?  No  Yes If yes, how much? \$
- 12. Does the hospice patient/decedent have life insurance that will help pay a portion of the expenses?  No  Yes If yes, how much? \$
- 13. Has State/County burial/funeral assistance been applied for?  No  Yes
- 14. Has State/County burial/funeral assistance been awarded?  No  Yes If yes, how much? \$
- 15. Has the VA been contacted for burial/funeral assistance?  No  Yes
- 16. Has VA burial/funeral assistance been awarded?  No  Yes If yes, how much? \$

17. **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:

Street Address:  City/State/Zip:

Contact Name:  Contact Phone:

Funeral Home Email Address:

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

18. Are you the hospice patient/deceased for whom funeral arrangements are being made?

Yes. *Please sign below.*

No, but I have **financial** power of attorney (FPOA) for the individual named in question 1. on this form. *Please attach FPOA form and sign below as attorney-in-fact.*

No, hospice patient unable to sign, no FPOA available. *Leave signature blank.*

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**  
7755 3rd Street N, Suite 200  
Oakdale, MN 55128-5442

*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 or the application will not be reviewed.*

### NOTIFICATION PROCESS

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

\$1,500 or less:	Within 10 business days of submission
Greater than \$1,500:	Within 15 business days of submission
Emergency Request:	Within 72 hours of submission

**Notification Letter:**

A notification letter will be mailed or emailed to the contact information provided on the first page of 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.