HOSPICE SUPPORT FOUNDATION

GRANT APPLICATION FORM - FINAL WISH/BEREAVEMENT/OTHER

version 03122025

IMPORTANT: Please read this section first 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 a final wish of a current hospice patient, bereavement assistance for loved ones of a deceased hospice patient or other areas of support that Hospice Support Foundation offers.
This form is not to be used for Funeral Assistance/Memorial Services. There is a designated form for Funeral Assistance/Memorial Services.

Grant awards are based on current household income and assets. HSF is unable to pay individuals directly, but rather, pays vendors directly. HSF is unable to provide assistance if the request has already been paid for or has already occurred. HSF is unable to rent vehicles on behalf of grant recipients. Please allow for a minimum of 15 business days to review final wish requests. If a final wish request is for a patient whose condition is iminent, please call us immediately.

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 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.

APPLICANT INFORMATION

1. Applicant Name:

2. Has applicant received prior HSF support? ◯ No ◯ Yes

3. Applicant Mailing Address:

Street

City | State | Zip Code | County

4. Applicant/Responsible Party Phone Number:

5. Applicant/Responsible Party Email Address:

6. What is Applicant's affiliation with hospice?

◯ Currently enrolled in hospice care ◯ Loved one is enrolled in hospice care

◯ Hospice worker - *please continue to number 7.*

◯ Other - *explain:*

**If you are a charitable organization seeking assistance, please attach your IRS determination letter or provide your EIN.*

7. If you are an employee of a hospice organization and are completing this request for yourself or assisting a current hospice patient/loved one with this request, please provide the following information:

Employee Name | Job Title

Direct Telephone | Branch Location

APPLICANT FINANCIAL INFORMATION

Reasonable, good faith estimates are acceptable in this section.

8. Applicant Status: ◯ married ◯ single ◯ Charitable Organization (skip to bottom of page)

If married, please provide joint financial information.

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

Charitable Organization Financial Information

If you are a charitable organization applying for assistance, please provide the following with your application:

☐ IRS Determination Letter

☐ Tax ID/EIN:

☐ Copy of Statement of Financial Position/Balance Sheet ending most recent fiscal year end

☐ Copy of Statement of Activities/Income Statement ending most recent fiscal year end

GENERAL INFORMATION

9. Please tell us how much you are requesting: $

10. What type of request is this?

- ◯ Final Wish Experience
- ◯ Hospice Worker Assistance
- ◯ Bereavement Activity/Grief Camp
- ◯ Education Event
- ◯ Charitable Organization Grant
- ◯ Other

11. Please tell us more about why you are seeking this assistance:

12. Please itemize below the cost of the request. *Descriptions of specific items should be included below or on a separate page. URLs of specific items are very helpful. If this application is approved, we will purchase exact items described here and will not be able to return/exchange incorrect items. Please be as accurate and descriptive as possible. Attach additional pages if needed.*

CONTINUED FROM PREVIOUS PAGE....

13. If you are requesting a Final Wish grant, do you have ☐ a credit card ☐ a debit card ☐ neither

VENDOR PAYMENT INFORMATION

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

Vendor Name

Street Address | City | State | Zip Code

Contact Name | Contact Phone

Vendor Email Address

Additional Vendor Information (if needed)

Vendor Name

Street Address | City | State | Zip Code

Contact Name | Contact Phone

Vendor Email Address

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

14. Are you the individual receiving the benefit of this grant?

◯ Yes. *Please sign below.*

◯ No, I have financial power of attorney (FPOA). *Please attach FPOA form and sign below as attorney-in-fact.*

◯ No, individual unable to sign, no FPOA available. *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.*

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.

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

Date Received

☐ Complete ☐ Incomplete

Missing Information/Additional Information Requested

☐ Approved $ Amount Approved

☐ Denied Reason for Denial

Date Notification Letter Sent

☐ By Email ☐ By Mail

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