FRIENDS of HOSPICE
SOUTHWEST WASHINGTON
funding comfort since 1985

Friends of Hospice Southwest Washington

Patient Benefit Request Form

Patient Eligibility

The patient must reside in Southwest Washington.

For funeral assistance and charity requests:

- Be receiving hospice or palliative care in **Southwest Washington** through a hospice organization with a valid Washington State Certificate of Need.
- Be enrolled in or qualify for Washington Medicaid or receive 100% financial assistance from the hospice organization.
- Patient must be living at the time a charity request is submitted.

For respite requests, patient and family must lack sufficient financial resources to cover the requested expense.

If the patient does not meet the Medicaid or 100% financial assistance requirement, please provide specific details explaining the patient's financial circumstances and why an exception to this requirement is warranted.

Currently Eligible Organizations: PeaceHealth Southwest Hospice & HomeCare | NW Kaiser Permanente Hospice & Palliative Care Services | Eden Healthcare | Shalom Hospice of Southwest Washington | Providence Hospice

Request Information

Date: _____ **Funds Needed By:** _____

Patient Name (first name and last name initial): _____

Date of Death, if applicable: _____

Organization: _____

Social Worker: _____ **Phone:** _____

Email: _____

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Benefit Requested:
☐ Funeral Assistance — **up to $350 per patient**
☐ Respite Care — **up to $3,000 per patient, one time**
☐ Charity Care — **up to $3,000 per patient, one time**

Amount Requested: $_____

Description of Expense/Services <u>including service provider</u>:

_____

_____

Eligibility Certification

☐ Patient meets the Medicaid or 100% financial assistance requirement.

☐ Patient and family lack sufficient financial resources to cover the requested expense.

☐ Patient does not meet this requirement. **Specific circumstances supporting the request:** _____

_____

I certify that the information provided is accurate and that the patient meets the applicable eligibility requirements or that sufficient information has been provided for Friends of Hospice Southwest Washington to consider an exception.

Social Worker Signature: _____ **Date:** _____

Supervisor Approval

I have reviewed and approved this request and confirm that the information provided supports the patient's eligibility or request for an exception.

Supervisor Name: _____

Supervisor Signature: _____ **Date:** _____

FOH Use Only

Date Received: _____ **Approved:** ☐ Yes ☐ No

Amount Approved: $_____ **Payment Date:** _____

Notes: _____