



Grant Application

Does this patient have Life Insurance? Yes No		Date of request:
Compassus office name/city:		
Office Telephone: ()		Social Worker Cell Phone: ()
Social Worker Name:		Patient Diagnosis:
Patient Name:		Time on hospice services:
Patient Address:		
City:	State:	Zip:
Detailed request/Explanation of need:		
List local resources, and outcome, researched for additional funding of this request:		
Grant amount requested: \$		

Foundation Office Use Only:

Date Received:	Decision Date:	Grant Amount Approved: \$
Notes:		

Income & Expense Worksheet for Individual/Family

Name of person(s) requesting assistance:	Contact Phone #: ()
Name of person(s) Income & Expense Worksheet pertains to:	

Monthly Total Household Income:

Wages (before tax):	\$
Investment Income:	\$
Social Security/Retirement Plan Income:	\$
Other Income (i.e. State assistance, Child support...)	\$
TOTAL MONTHLY INCOME:	\$

Monthly Expenses:

Mortgage/Rent:	\$	Property Tax (break down monthly):	\$
Homeowner/Renter Insurance:	\$	Electricity:	\$
Gas:	\$	Telephone:	\$
Water:	\$	Cable TV:	\$
Car Payment(s):	\$	Car Insurance:	\$
Gasoline:	\$	Public Transportation:	\$
Groceries:	\$	Medical/Dental/Vision Care Insurance:	\$
Personal Care (clothing, hair care, etc.):	\$	Child Care:	\$
Credit Cards:	\$	Life/Health/Disability Insurance:	\$
Other Expenses (list below):			
	\$		\$
	\$		\$
TOTAL MONTHLY EXPENSES:			\$

Income & Expense Worksheet for Individual/Family

Personal Assets:

Checking, Savings, Stocks, Bonds:	\$
Retirement Savings (i.e. 401k)	\$
Home Equity:	\$
Automobile(s):	\$
Other Assets (i.e. significant land, buildings, equipment, etc.)	\$
TOTAL ASSETS:	\$

Personal Liabilities

Home loan debt:	\$
Automobile loan debt:	\$
Credit Card debt:	\$
Other debt:	\$
TOTAL LIABILITIES:	\$

The financial information I have provided is true to the best of my knowledge.

 Signature of person providing financial information Date _____

Social Work Notes/Special Considerations:

RE: Patient Name _____ Grant Application

PLEASE NOTE: Terms of approval will be honored for up to 6 months, at which point in time, a new application would need to be submitted for re-consideration. Patient must be on service with Compassus (or recently passed) at the time payments are made.

Social Worker Signature: _____ Date: _____

ACO or DCS Signature: _____ Date: _____

Please print name: _____

Please email completed form to Rebecca.Tillman@compassus.com