



## Grant Application

Does this patient have Life Insurance?    Yes        No	Date request is sent to foundation:	
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 result), researched for additional funding of this request:		
<b>Grant amount requested: \$</b>		

***Foundation Office Use Only:***

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

### Income & Expense Worksheet for Individual/Family

Name of family member requesting assistance:	Contact Phone #: (    )
Name of family member who the 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...)	\$
<b>TOTAL MONTHLY INCOME:</b>	<b>\$</b>

**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):			
	\$		\$
	\$		\$
<b>TOTAL MONTHLY EXPENSES:</b>			<b>\$</b>

**Income & Expense Worksheet (cont.)**

**Personal Assets:**

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

**Personal Liabilities**

Home loan debt:	\$
Automobile loan debt:	\$
Credit Card debt:	\$
Other debt:	\$
<b>TOTAL LIABILITIES:</b>	<b>\$</b>

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

\_\_\_\_\_ **Date** \_\_\_\_\_  
 Signature of family member providing financial information

**Social Work Notes/Special Considerations:**

---



---



---



---



---

**Social Worker Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

RE: Patient Name \_\_\_\_\_ Grant Application

ACO or DCS Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please print name of ACO/DCS: \_\_\_\_\_

**Please email completed application to: [LivingFoundation@Compassus.com](mailto:LivingFoundation@Compassus.com)**

***PLEASE NOTE: Terms of approval will be honored for up to 60 days. If the approved bills are not received in that time, a new application will need to be submitted for re-consideration. Patient must be on service with Compassus (or recently passed) at the time payments are made.***