A Better Way
Memorial Fund

Grant Application

Please complete this application to the best of your ability. Missing information may affect the decision for funding.

Name of Requesting Hospice: _____

Is this Hospice accredited? ☐ Yes ☐ No If yes, by whom? ☐ Joint Commission ☐ ACHC ☐ Other _____

Authorized Representative's Name: _____

Contact Information: Work Phone: _____ Cell Phone: _____

Mailing Address: _____

_____ E-mail _____

Name of Hospice Patient: _____

Hospice Diagnosis: _____

Emergency Contact: _____ Phone: _____

Request – Please be as specific as possible (i.e., what the patient needs, why it is needed, what other resources are available to them, etc.). Attach additional sheet(s) if necessary.
Maximum grant is $500.

_____

_____

_____

_____

_____

_____

_____

Amount Requested: $_____

_____ _____

Authorized Representative's Signature Date

A Better Way
Memorial Fund

Consents

_____ I understand that by signing this form, I am giving A Better Way Memorial Fund permission to grant my request. I also understand that if they are not able to approve this request, an alternate request may be made. All travel requests must be approved by the hospice physician of the patient's PCP.

_____ I understand that taking part in any activity ha certain dangers, and I agree to hold harmless A Better Way Memorial Fund, Inc., it's staff, Board of Directors, and volunteers for any and all claims or causes of action, whether now know or unknown, arising from the award of this grant.

_____ I understand that A Better Way Memorial Fund, Inc. is not responsible for any costs beyond this grant. Costs not covered unless specified in the application would include, but not be limited to, medical costs, hospital stays, or emergency transportation.

_____ I hereby give my permission for press coverage, if applicable, of any "wish" granted.

_____ I hereby give A Better Way Memorial Fund, Inc. permission to use any pictures related to this grant request for publicity purposes, understanding only my first name would be used, unless I give permission to use both my first and last name.

Patient's Name: _____ Signature: _____

Witness Name: _____ Signature: _____

A Better Way Memorial Fund Representative: _____

Signature: _____ Date: _____

A Better Way Memorial Fund

A Better Way Memorial Fund, Inc.

Medical Information Form

I, _____, do hereby give my permission for my doctor, _____, to release any medical information to A Better Way Memorial Fund, Inc. I understand this information will be kept confidential by A Better Way Memorial Fund, Inc.

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The following is to be filled out by the hospice physician or the PCP. Fax completed copy to (208) 322-6087.

Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The patient listed above has been diagnosed with :_____

_____

Please check all of the following that are true:

_____ The Patient listed above is my patient.

_____ The patient listed above has a terminal illness.

_____ The patient listed above does not have a terminal illness.

Doctor's Signature: _____ Date:_____

For more information, please call. (208) 322-4663 and ask for Erin Danzer.
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A Better Way Memorial Fund

Grant Request Guidelines:

A Better Way Memorial Fund, Inc. provides financial support to those individuals on hospice who are unable to cover expenses incurred during the final stages of life. These expenses can include, but not be limited to hospice care, living expenses, final wishes, or home modification costs, to name a few examples. Review of the applications is subjective, so we encourage you to provide as much compelling information as possible about why the funds are needed, as well as the timeline desired. Supporting documentation (i.e., bills, invoices, statements, project costs, etc.) will be helpful as the application is being reviewed.

Applications are accepted year round, so there are no deadlines for application. All information requested on the application must be complete. Missing information may affect the funding decision. Maximum grant awarded is $500.

All applications will be reviewed and considered for approval. We make every effort to approve as many requests as possible. That said, there may be times when there are inadequate funds to meet the needs of our applicants. In these cases, the request will be returned to the sponsoring hospice so they may pursue other avenues of funding for their patient. **All decisions are final.**

Upon acceptance of a grant from A Better Way Memorial Fund, Inc., the sponsoring hospice agrees to:

1. Ensure the funds are utilized for the purpose intended.
2. Provide receipts to document how funds were spent.
3. Provide photographs whenever possible to document how the funds were spent.
4. Repay any excess funds that were not used for the approved purpose.
5. Provide a brief summary of how the funds were used, to be submitted with the documentation mentioned above.

I understand and agree to abide by the provisions listed above.

_____ _____

Signature of Hospice Representative Accepting Funds Date

_____ _____

Signature of Executive Director, ABWMF Date

For Office Use Only:

Date Application Received	Date Application Reviewed	Reviewer Initials
$ Amount Requested	Approve ☐ Deny ☐	
Date Applicant Was Notified	Date Funds Were Disbursed	Summary Rec'd