Humboldt County Hospice Foundation
BOX 183, Humboldt, IA 50548
515-332-4200
www.humboldthospital.org

Funding Application

• The first 3 days in Hospice Hospitality will be granted if the patient or family verbally requests financial assistance. After the 3 days, this application must be filled out and approved to be granted 4 additional days.
• Only the first 7 days will be covered by this program.
• If further Hospice Hospitalty days are needed after the 7 day approved stay is up, a reevaluation of the patients status will occur.
• Please be advised that applications are on a first-come-first-served basis and due to the high demand of requests, there is no guarantee that at the time of your application the funds will be available.
• For other financial aid assistance please call our Business Office at 515-332-4200.

Patient Name_____ DOB:_____

Address_____

City_____ State_____ Zip Code_____

Phone_____ Email_____

Date(s) of Hospitality Stay: _____

Extension date(s) of Hospitality Stay:_____ Inital:_____

Do you receive help from any of the below state program(s):

☐ Food Stamps ☐ WIC ☐ Waiver Program (please specify):_____

☐ Other (please specify):_____

Do you have insurance? Circle: YES or NO

If yes, name of insurance provider(s): _____

Do you have liquid assests (checking and savings) of less than $5,000? Circle: YES or NO

If yes, provide 3 months of bank statements, checking/savings, include ALL pages within 3 business days.

By submitting this application, the patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

Applicant Signature:_____ Date:_____

Approval Signature: _____ Date:_____

*Please submit form to Inpatient Care at 1000 15th Street North, Humboldt, IA 50548.
Forms may also be dropped off at the nurses station.
For questions please call the Humboldt County Hospice Foundation at 515-332-4200.