



# Northwest Michigan Hospice Assist

*Helping those who need it most with support and resources for terminally ill patients, their families, and caregivers*

Northwest Michigan Hospice Assist offers grants to patients and their families facing terminal illness and self-care packages to the caregivers who care for them when they need it most.

Grants are offered for related care expenses of up to \$500 based on our granting budget and the donations we receive from generous donors with a heart for those in hospice care.

These grants do not need to be repaid. We don't ask a patient or their family to take on debt, our goal is to relieve stress and not give another financial burden during the most challenging time in their life.

A few examples of how a grant from Northwest Michigan Hospice Assist financial can help are:

- Receiving a fuel gift card to help defray the cost of transporting patients
- Contribute to prescription costs
- Supply a patient with personal care items that enable cleanliness and dignity

Another important mission for us is recognizing and supporting those who care the most, the caregivers. We gift them with a NMHA Caregivers Care Package that is filled with items to promote self care and stress relief during challenging times

We also help refer qualified caregivers to work in a patient's home if they need it. We provide resource information as well that may help people find further assistance and information.

Please fill out the attached the application on the reverse of this page and return it to:

**Northwest Michigan Hospice Assist**  
**PO Box 762, Bellaire, MI 49615**  
**Call for office hours at:**  
**201 State Street Suite D Charlevoix, MI 49720**  
**231-303-3500**

# Patient and Caregiver Grant and Care Package Application

Northwest Michigan Hospice Assist is a 501(c)3 non-profit compassionate care organization that provides financial grants and resource support for those facing terminal illness and loss in Antrim, Charlevoix, and Emmet counties.

Are you a \_\_\_\_\_ Patient or a \_\_\_\_\_ Caregiver

Date of Application \_\_\_\_\_

Applicant Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Contact Person for Patient \_\_\_\_\_

Phone Number \_\_\_\_\_

Type of Request: \_\_\_\_\_ Financial grant \_\_\_\_\_ Caregiver's Care Package \_\_\_\_\_ Referral/Information

Describe how you will use grant funds, please include additional information on a separate sheet if desired:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you are applying on behalf of a caregiver, please describe their services and why you believe they will benefit from receiving an NMHA Caregivers Care Package, please include information on a separate sheet if desired:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Office Use Only

Case # \_\_\_\_\_

Date application received \_\_\_\_\_ Interview date \_\_\_\_\_ Board review date \_\_\_\_\_

Board comments/decision \_\_\_\_\_

Check # \_\_\_\_\_ Sent date \_\_\_\_\_ Clear date \_\_\_\_\_

Follow up date and comments \_\_\_\_\_