

HOSPICE APPLICATION FOR NUTRITIONAL SUPPLEMENTS

Date: _____

County of Residence: Spartanburg Cherokee _____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Preferred Name _____ **Email** _____

Date of Birth: _____ **Sex:** Male Female Other

Spouse/Significant Other: _____

Mailing Address: _____

City: _____ **State** _____ **ZIP** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Race: Caucasian (White) African American (Black) Hispanic/Latino Asian Other _____

Name of Hospice Group: _____ **Main Phone:** _____

Hospice Representative: _____ **Cell Phone:** _____

Representative Email: _____

On hospice care due to cancer diagnosis? Yes No

Cancer Diagnosis: _____ (date diagnosed: _____)

Veteran in Household? YES NO

Other Assistance Requested: Wig Counseling (Patient and/or Family)

IN ORDER TO BETTER SERVE YOU, THE FOLLOWING INFORMATION MUST BE COMPLETED:

Estimated Total Household Income: \$0-14,579 \$14,580-19,719 \$19,720-24,859 \$24,860-29,999 \$30,000-35,139
 \$35,140-40,279 \$40,280-45,419 \$45,420-50,559 \$50,560 + up

Number Living in Household: _____

Major Medical Insurance Private Insurance Medicare Medicaid None