

# Namaste Comfort Fund Application for Direct Assistance

**Note:** Please review all assistance criteria, exclusions, and conditions prior to completing application. Please provide all information as completely as you can. Personal and medical information requested on patient-recipients is for confirmation of criteria and internal tracking purposes only and will be held in strict confidence. If you have questions, call 303-860-9915, and ask for the Namaste Comfort Fund Executive Director. **On completion, fax this form to: 303-860-9914 or mail to: Namaste Comfort Fund, 1633 Fillmore, Suite 300, Denver, CO 80206**

Date: \_\_\_\_\_

Regular request  
(7 to 10 days to process)

Urgent request  
(48 hours to process)

Applicant's name: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Direct phone: \_\_\_\_\_ Email: \_\_\_\_\_

Pager/cell/other (specify): \_\_\_\_\_

Person for whom request is being made: \_\_\_\_\_

Has this person or his or her authorized agent or guardian granted consent to your making this request and disclosing relevant medical and personal information?  Yes  No (Note: Consent is required!)

What is this person's: Age: \_\_\_\_\_ Sex:  Male  Female Race: \_\_\_\_\_

Does this person have:  Private insurance  Medicare  Medicaid  No insurance  Don't know

What is this person's diagnosis/condition? \_\_\_\_\_

In what city does this person live? \_\_\_\_\_

Assistance request is for (specify item or service): \_\_\_\_\_

This is a one-time request **OR**  This request is for an ongoing service of \_\_\_\_\_ days weeks months  
(circle one)

Exact amount requested: \_\_\_\_\_

(Provide exact, documented purchase price of items or all applicable costs of services.)

This amount to be paid to: \_\_\_\_\_

Requests for retail items less than \$100 will be paid as reimbursements to individuals. Following approval of application, submit an explicit receipt showing date and location of purchase, item, and cost. If item will cost more than \$100.00 or if request is to cover an ongoing service, an invoice from the point-of-purchase company or service provider must be submitted.

In your own words, please tell us how this item or service will enhance the patient's comfort or quality of life and describe other resources you have explored prior to making this request. Please use more pages as needed.

*For Namaste Comfort Fund Office Use Only:*

Approved (date: \_\_\_\_\_ )  Check sent (date: \_\_\_\_\_ )  Denied / Regret sent (date: \_\_\_\_\_ )