



Compassion is Love in Action

The Love Light Compassion Foundation's mission is to designate assistance wherever there is need. We currently work with local, nonprofit health care organizations across the nation.

Love Light Compassion Foundation (LLCF) reserves the right to make individual gifts directly to applicants in need or block grants to qualifying organizations. Recipient organizations are required to provide a HIPPA compliant report on funds disbursed on a quarterly basis. (See guidelines.)

Qualifying institutions include hospitals, children's hospitals, cancer centers, and community health centers. Contact LLCF if your health care organization would like to be considered to be in our funding schedule. Please list contact person, position (social worker, patient navigator, etc.) and complete contact information. LLCF does not accept requests from institutional development and/or advancement offices.

Guidelines

Love Light Compassion Foundation accepts unsolicited applications from qualifying health care organizations, health care social workers, patient navigators or individuals. Once an application is reviewed, every effort is made to respond to approved requests within 48 hours.

Individual gifts are based on need with a maximum \$1,000 per patient/family/care-giving group. NOTE: Funds are paid directly to the vendor (rental office, utility company, etc.). Billing information will be requested upon approval of the application.

Block Grants are distributed up to \$10,000 with disbursement recommendation of up to \$1,000 per patient/family/care-giving group.

Follow-up requests will be considered after 6 months from initial gift/grant.

Applicant requirements:

- Provide name of health care organization affiliation
- Copy of IRS determination letter
- Credentials of representative applicant
- Specific information on the patient's financial distress due to their illness. (This allows us to prioritize and expedite requests.)
- Patient's request(s) and corresponding amounts. (e.g. medical bills: \$20.00, electric: \$68.00, rent: \$102.00, etc.)

For block grants:

- Provide name of health care organization affiliation
- Copy of IRS determination letter
- Credentials of representative applicant
- Amount of block grant request
- Quarterly report to LLCF on amounts distributed

Submit Love Light Compassion Foundation application to the email or address below.



Application for Support

Name: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Amount of request: _____

Please provide specific information on the patient's financial distress due to their illness. This allows us to prioritize and expedite requests. If you need more room, please enter this information in the body of your email.

LLCF will provide **up to \$1000** per patient. Please list specific request and corresponding amounts. (e.g. medical bills: \$20.00, electric: \$68.00, rent: \$102.00, etc.):

_____ \$ _____ _____ \$ _____

_____ \$ _____ _____ \$ _____

_____ \$ _____ _____ \$ _____

Referring Provider: _____

Name of healthcare organization affiliation: _____

- I authorize representatives of LLCF to contact my provider. (Must be checked in order for application to be considered.)

Signature _____ Date _____

Please attach a copy of IRS determination letter and submit this application via email to:
info@lovelightcompassion.org

or by mail to: Love Light Compassion Foundation; P.O. Box 1076; Shelburne, Vermont 05482
