

**INSTRUCTIONS and REQUIRED DOCUMENTATION**  
**For**  
**MEDICAL/PERSONAL NEEDS GRANT APPLICATION**  
**(Dentures / Hearing Aids / Glasses / Other)**

1. **Complete the Application as thoroughly and as detailed as possible.** Mississippi Health Care Foundation (MHCF) reserves the right to request additional documentation and/or information.
2. **PLEASE NOTE** the policy on broken or lost items and residents considered short stay that is located on the last page of the application form.
3. **Include the following Required Documentation with the Application:**

Confirmation from an appropriate professional that the item is needed i.e. dentist for dentures / ophthalmologist or optometrist for eyeglasses

Quote of the cost of the item being requested on the vendor letterhead or other vendor identifying documentation. A second quote is required as follows:

**DENTURES:** If the request for a full set of dentures exceeds \$800.00, a second quote is required. If the request is for an upper or a lower set of dentures exceeds \$400.00, a second quote is required. If you use a quote from a vendor website, you must document you called the vendor and confirmed the price.

**HEARING AIDS:** If the request is for hearing aids in both ears and the cost exceeds \$2120.00, a second quote is required. If the request is for a hearing aid in one ear and the cost is more than \$1110.00, a second quote is required.

\*\*The MHCF reserves the right to request second quotes on any grant request. \*\*

\*\* The Foundation does not pay for dental visits or consults. The facility is responsible for arranging for payment for this type of service.\*\*

The last six months of Resident's financial information i.e. Trust Fund, Bank Account

Attach any comments or supporting documentation from nursing, therapy or others about why this request is being made for the resident and why they think it would be of benefit to the resident

4. MHCF staff may be able to provide resources for reasonable priced grant requests.
5. Completed applications should be mailed or faxed to:

Mississippi Health Care Foundation  
303 Brame Road  
Ridgeland, MS 39157  
[foundation@mshca.com](mailto:foundation@mshca.com)  
Fax to: 601-898-8341

**(Please call 601-898-8320 to confirm the fax was received)**

6. If you have questions or need additional information, please contact MHCF at 601-898-8320..

# Mississippi Health Care Foundation

## Medical & Personal Needs Grant Application

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This form is to be used with the grant application information sheet when submitting a funding request for dentures, eyeglasses, hearing aids and other medical needs for an individual resident at a Mississippi-licensed skilled nursing care facility.

**Please be sure each question is answered with as much detail as possible before submitting application.**

Use additional pages if more space is needed and identify the question being addressed.

MCHF reserves the right to request additional documentation and/or information.

If you have questions or need additional information, please contact MCHF at 601-898-8320

Resident Name: \_\_\_\_\_

Resident Age: \_\_\_\_\_ Resident Gender: \_\_\_\_\_

Admit Date to Facility: \_\_\_\_\_ Expected Date of Discharge: \_\_\_\_\_

Resident considered: Short-Term Stay \_\_\_\_\_ Long-Term Stay \_\_\_\_\_

Resident Primary Pay Source at Facility: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Mailing Address: \_\_\_\_\_

Facility City/State/Zip: \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_ Facility Fax Number: \_\_\_\_\_

Contact Name – Please Print: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

Type of Item/Service Being Requested (Be Detailed): \_\_\_\_\_

\_\_\_\_\_

This application must have the signature of the Facility Administrator and at least one other facility staff member (must be Social Work Director, Activity Director, or Director of Nursing or other appropriate staff).

Administrator's Signature: \_\_\_\_\_

Secondary Signature & Title: \_\_\_\_\_

**Mail to:**  
**Mississippi Health Care Foundation**  
**303 Brame Road**  
**Ridgeland, MS 39157**  
**[foundation@mshca.com](mailto:foundation@mshca.com)**

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# Mississippi Health Care Foundation

## Medical & Personal Needs Grant Application

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4. If the item was lost/broken, what actions have been put into place to prevent this from occurring again?

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5. How will the resident benefit from the item?

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6. Describe the resident's current physical condition, health status and mental status:

Physical Condition: \_\_\_\_\_

Health Status: \_\_\_\_\_

Mental Status: \_\_\_\_\_

7. Please answer the following questions specific to the resident's financial status:

Does the resident have any available resources that may possibly be used to assist with the purchase of this item/service?

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What resources does the family have to assist with the purchase of the item/service?

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# Mississippi Health Care Foundation

## Medical & Personal Needs Grant Application

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What resources are available at your facility or what is your facility doing that may be Contributing to meeting this need of the resident?

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Describe other resources, if any, that have been explored. If funding was sought from other resources, explain why such funding was not granted.

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8. Answer the following question specific to the item being requested:

If the request is for DENTURES answer the following questions:

What type of diet is the resident receiving? \_\_\_\_\_

If the resident is on a regular diet, what has changed to cause the need for dentures?

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If the request is for EYEGLASSES answer the following questions:

If the resident has Medicaid, what was the date that Medicaid last paid for the resident's glasses? \_\_\_\_\_

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If the request is for HEARING AID(S) answer the following questions:

Has the resident used any kind of hearing device other than a hearing aid, such as amplifier?

Yes                            No

# Mississippi Health Care Foundation

## Medical & Personal Needs Grant Application

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If yes, when was the last time the resident used the device and why it is no longer an option?

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If the request is for a hearing aid that is not an external hearing aid, explain why an external hearing aid cannot be used by the resident.

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# **Mississippi Health Care Foundation Medical & Personal Needs Grant Application Policy Statements**

## **Policy: Eligibility for Grant**

It is the general policy of the Mississippi Health Care Foundation to only consider grant applications on residents residing in Mississippi Nursing Homes with an anticipated length of stay of one hundred days or more.

## **Policy: Lost/Broken Items**

The Mississippi Health Care Foundation receives frequent requests to replace items that are lost or broken in the nursing home. It is the general policy of the Foundation that the replacement of items lost in the facility is the responsibility of the facility. The general policy for broken items is that this is also a facility responsibility unless justification can be provided that the item is broken due to age, normal usage by the resident, etc.

If the item was purchased by the Foundation and lost or broken within 12 months of the date of purchase, the Foundation will not consider replacing the item. If it has been more than 12 months, the policy in the above paragraph will be applied.