Grant Application - Medical Event

Employee Name: ____

Last First Middle

Current Street Address: ____

City: ____________________________________ State: ____________ Zip: ________________

Email Address: ___________________________________ Phone Number: _________________

Facility/Location: ____

Current Job Title: ___________________________________ Date of Hire: _____/_____/_____

Employment Status: □ Active □ Inactive Status: □ FT □ PT □ PRN

Event Details: (please use a separate sheet of paper if additional space is needed)

Date of Event: _______________________

Event Type – Explain in detail: (attach supporting documentation)

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Relationship to Employee: _____________________________

Is employee financially responsible? □ Yes □ No

Has health insurance been applied to medical bill? □ Yes □ No

Have you reached out to the provider to see about financial assistance? □ Yes □ No

If yes, what were the results?

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Explain financial hardship caused by the event and any out of pocket costs: (attach supporting documentation)

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I acknowledge that the decision of the Share To Care Fund Committee is final. I certify that the information provided, and any accompanying materials/documentation is complete and accurate to the best of my knowledge. If the information in this application form changes, I will notify the Share to Care Fund Committee immediately. I understand that this application may be denied or withdrawn if it is incomplete and/or if any information reported is found to be intentionally misleading, inaccurate, or fraudulent. I agree that the Share to Care Fund Committee has the right to validate any information provided and will reclaim any money that has been paid as a result of fraudulent or misleading claims.

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Employee/Applicant Signature Printed Name Date