APPLICATION FOR A GOLDEN CROSS GRANT

This page is to be filled out by the Pastor.

In addition to information on this page, the pastor is requested to write a brief letter describing the need. Mail the completed application, the pastor's letter and any supporting material (copies of medical bills, etc) to Tom Hunter, [redacted] Mail a copy of the application and pastor's letter to your District Director of Golden Cross.

Name of Applicant _____ Age _____

Address _____

Marital status (adults) _____(S) _____(M) _____ (W)

If applicant is a child or teen, name of parent(s) _____

Employment status: Of Applicant _____

Of Applicant's Spouse (or parents if applicant is a child) _____

Member of _____ U M Church No. Years ____ District _____

Pastor _____ Phone _____

Address _____

Has the applicant or family received a previous Golden Cross Grant? _____No _____Yes

If yes, when? _____ Reason: _____

(If more space needed, use the backside of this form)

What assistance, financial or otherwise, has been given applicant/family by his/her/their Church?

_____

Applicant's Medical situation

Diagnosis _____

Therapy indicated/recommendation of physician _____

_____

( ) Out-Patient ( )Hospitalization Length of Stay _____ ( ) Surgery

Prognosis _____

Name of Hospital/Clinic/Medical Group, Etc. _____

( ) A copy of this application is being sent to the District Director of Golden Cross

( ) Copies of medical bills are enclosed

Pastor's Signature (Supporting this request) _____ Date _____

Conference Director's Signature (approving the grant) _____

Date _____ Amount of Grant $ _____

APPLICATION FOR A GOLDEN CROSS GRANT, page two

This page may be filled out by the Pastor or by the Applicant and/or family

Name of Applicant _____

FINANCIAL INFORMATION

Financial Ability ( ) None ( ) Limited ( ) Modest

Optional. This is not required, but it would be helpful if the applicant/family shared information about resources, income, indebtedness, financial obligations, etc. *(An extra sheet may be attached if needed.)*

INSURANCE INFORMATION – Insurance Coverage

( ) None ( ) Medical insurance/HMO? Provider (Ins. Company)_____

Type (amount) of coverage_____

( ) Medicare ( ) Medicare supplement ( ) Medicaid ( ) other_____

CURRENT MEDICAL BILLS (applicable to this Golden Cross application)

If exact amounts are not known, please estimate as accurately as possible.

Total amount of medical bills to date $_____

Amount of these bills paid to date: (amount or percentage)

By Insurance/HMO, Medicare, Medicaid, etc. $_____

By the applicant's Church $_____

By other persons, groups, local assistance ministries, etc. $_____

By the applicant and/or his or her family $_____

Total Paid to date $_____

Balance due to date $_____

What amount or percentage of the "balance due to date" is expected to be paid by:

Other sources (Insurance, Medicare, church, etc.) $_____

The applicant and/or his or her family $_____

Estimated amount of additional medical bills expected later: $_____

What amount or percentage of these additional bills will be paid by:

Insurance, Medicare, etc.? _____ The applicant and/or family? _____

Signature (person completing this page)_____ Date _____