APPLICATION FOR A GOLDEN CROSS GRANT

FOR ASSISTANCE WITH COSTS OF PRESCRIPTION DRUGS.

The pastor is to submit a letter with the application describing the need. Mail completed application and supporting material to Tom Hunter, PO Box 696, Pilot Mountain, NC 27041. You must also send a copy to the District Director of Golden Cross.

Name of Applicant____Age__________

Address____

Member of ________________________U M Church No. Years___District_______________

Pastor____________________________________ Phone ___________________________

Pastor's Address____

Has the applicant or family received a previous Golden Cross Grant? Yes_____ No_____
If Yes, when?_________ Reason____

Medical situation of applicant____

Prognosis ____

Prescribed medications ____

Financial Ability None _____ Limited ______ Modest ______

Does the applicant have Insurance/HMO ______ Medicare _____ Medicare Supplement _____
Is the applicant receiving assistance from Medicaid? Yes _____ No _____

Are any of the prescription medications covered by Insurance/HMO, Medicare or Medicaid?
Yes____ No _____ If yes, amount/percentage _________________________________

Is the applicant receiving assistance with cost of medications from Church or Community Assistance Programs? Yes ____ No____ If yes, how much? __________________________

Does the applicant have other significant medical costs in addition to medicine? Yes_____ No____
If yes, amount? for? ____

Does the applicant have unpaid bills for prescription drugs? No____ Yes ____ Amount $________
Name/Address of Pharmacy____

Important: Please include with this application a pharmacy "print-out" listing applicant's prescription medication and amount paid by applicant for previous 3 months minimum.

Pastor's Signature (approving request) ______________________________ Date _____________

Conference Director's Signature (approving grant) _____________________________________

Date _______________________ Amount of Grant $______________________