



**GOLDEN CROSS/ONE WHO IS LOVED Benevolent Funds Application**  
**North Carolina ANNUAL CONFERENCE**  
**OF THE UNITED METHODIST CHURCH**

The Golden Cross Benevolent Fund supports the laity of any age in our Annual Conference who are experiencing financial difficulty due to excessive medical expenses such as hospital/physician services, dental, pharmacy, mental health, vision needs, home health services and medical travel expenses. The One Who Is Loved Endowment benefits children under the age of 18 who have special needs such as specialized medical equipment or supplies/medicine, transportation to hospitals or treatment centers, or other special needs. Applicants for both grants must be members (or have at least one parent who is a member) of a local United Methodist Church and be recommended by their pastor.

Name of Applicant/Child \_\_\_\_\_ Date \_\_\_\_\_

Age of Applicant/Child \_\_\_\_\_ Number of Dependents (living in home) \_\_\_\_\_

Monthly Household Income (from all sources) \_\_\_\_\_ Pastor's name \_\_\_\_\_

Member of \_\_\_\_\_ United Methodist Church in \_\_\_\_\_ District

Applying for (check one or both, if applicable): Golden Cross Grant \_\_\_\_\_ One Who Is Loved Grant \_\_\_\_\_

Please attach a statement in your own words describing your situation and why you are applying for assistance. The maximum annual grant for Golden Cross is \$2,500; for One Who Is Loved it is \$1,000.

I hereby request \$ \_\_\_\_\_ in assistance. I certify that this is a need which cannot be met without extreme and undue financial hardship. (If an applicant other than the patient signs this form, please attach an explanation.)

Signature of Applicant/Child's Parent \_\_\_\_\_ Date \_\_\_\_\_

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**Pastor's Statement of Verification/Recommendation**

Pastor: Please attach a statement describing the applicant's/child's medical needs and why you believe this person is eligible for assistance. Include in your statement: 1) amounts owed in medical bills, 2) assistance and support from relatives, friends, church, insurance, social service agencies, or any and all potential resources, 3) any other information you would like to share about their situation. **I certify, that in my judgment, this is a bonafide need which cannot otherwise be met without extreme financial hardship on the applicant.**

Pastor's Signature \_\_\_\_\_ Date \_\_\_\_\_

I recommend aid for \_\_\_\_\_ be approved as follows:

If applying for Golden Cross, list the information below pertaining to the provider(s) who will receive payment (Physician, Hospital, Pharmacy, etc). Attach a detailed listing if necessary. If applying for One Who Is Loved, list the child's parent's name and address to whom the grant will be payable.

| Name | Address | Amount |
|------|---------|--------|
|      |         |        |
|      |         |        |
|      |         |        |

Mail application to: **Benevolent Fund Administrator**  
**700 Waterfield Ridge Place**  
**Garner, NC 27529**

Contact for questions: **919-779-6115 ext. 316**    **benefitsteam@nccumc.org**

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**Office Use Only**

Received \_\_\_\_\_ Approved \_\_\_\_\_ Denied \_\_\_\_\_

If approved, amount \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_