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_____