The Shepherd's Fund
Retired Pastors Benevolence Program

Date _____ **Conference** _____ **District** _____

Full Name _____ **Date of Birth** _____

If spouse of pastor include pastors name _____

Address _____

City _____ **State** _____ **Zip** _____

Primary Phone _____ **Email** _____

Physician's name and phone number _____

Total Expected Medical Expense _____ **Expense request for next 12 months** _____

Years of Service in The United Methodist Church _____

Please indicate the following that apply:

- ☐ **Methodist Pastor, Elder, etc. in Good Standing with your Conference**
- ☐ **Retired**
- ☐ **Disabled**
- ☐ **Other:** _____

Describe the medical situation you have encountered and the financial need you are experiencing as a result. Include information regarding your capacity to meet that need:

I certify that the above is true and correct and authorize the Shepherd's Fund Committee to consider my statements in application for a grant. If any of the above statements change prior to the grant award being made, I will provide an update to the Shepherd's Fund Committee.

_____ _____

Applicant Signature *Center for Clergy Excellence or DS Signature*

_____ _____

Printed Name *Printed Name*