

The Golden Cross Application for Financial Assistance Please Give Complete and Detailed Information – Type or Print

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| Date of this Application: | | | | |  | | | | | | | | | | | | | | | |
| **APPLICANT INFORMATON** | | | | | | | | | | | | | | | | | | | | |
| Full Name: |  | | | | | | | | | | | | | | | | | | | |
| Date of Birth: |  | | | | | | | | | Date of Illness/Injury: | | | | | |  | | | | |
| Street Address: |  | | | | | | | | | | | | | | | | | | | |
| City, State, Zip |  | | | | | | | | | | | | | | | | | | | |
| E-mail Address: |  | | | | | | | | | | | | | | | | | | | |
| Primary Phone: |  | | | | | | | | | | Secondary Phone: | | | | |  | | | | |
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| **APPLICANT CHURCH INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| Church Name: |  | | | | | | | | | | | | | | | | | | | |
| Senior Pastor |  | | | | | | | | | | | | | | | | | | | |
| Pastor’s E-mail: |  | | | | | | | | | | | | | Church Phone: | |  | | | | |
| United Methodist District Name: | | | | | | | |  | | | | | | | | | | | | |
| Has the church or district assisted this person financially? | | | | | | | | | | | | | | | | Yes |  | No | |  |
| If yes, please give details. | | | |  | | | | | | | | | | | | | | | | |
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| Has the applicant received Golden Cross funds before? | | | | | | | | | | | | | | | | Yes |  | No | |  |
| If yes, when and what amount? | | | | | | |  | | | | | | | | | | | | | |
| If applicant is not a United Methodist, explain why this assistance should be given. | | | | | | | | | | | | | | | | | | | | |
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| **APPLICANT FINANCIAL & INSURANCE INFORMAITON** | | | | | | | | | | | | | | | | | | | | |
| Amount of financial golden cross grant requested : | | | | | | | | | | | | | | |  | | | | | |
| Average Monthly Income: | | |  | | | | | | | | | | | | | | | | | |
| Employer of applicant or other person responsible for medical expenses: | | | | | | | | | | | | | | | | | | | | |
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| If currently unemployed, applicants last place of employment: | | | | | | | | | | | | | | | | | | | | |
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| Length of employment: | |  | | | | | | | | | | | | | | | | | | |
| Persons financially dependent on applicant: | | | | | | | | | | | |  | | | | | | | | |
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| **Personal Resources**: | | Complete all resources below that apply to applicant. | | | | | | | | | | | | | | | | | | |
| Primary Home | Own |  | | | | Rent | | |  | | | | Secondary Home | | | Own | | | Rent | |
| Vehicles: |  | | | | | | | | | | | | | | | | | | | |
| Investments: |  | | | | | | | | | | | | | | | | | | | |
| Cash available: |  | | | | | | | | | | | | | | | | | | | |
| Amount of Debt: |  | | | | | | | | | | | | | | | | | | | |

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| **Insurance** | Do you have private health insurance? | | | | | | | | | Yes | |  | | No | |  | |
| If yes, name: |  | | | | | | | | | | | | | | | | |
| Do you have? | Medicare | | Yes / No | | |  | | Medicaid | | | | | Yes / No | | | |  |
| Home Owners | | Yes / No | | |  | | Motor Vehicle | | | | | Yes / No | | | |  |
| Worker’s Compensation | | | | | | | Yes / No | | | | |  | | | | |
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| **APPLICANT MEDICAL INFORMATION** | | | | | | | | | | | | | | | | | |
| Medical Provider Name: | |  | | | | | | | | | | | | | | | |
| Street Address: |  | | | | | | | | | | | | | | | | |
| City, State, Zip: |  | | | | | | | | | | | | | | | | |
| Phone number: |  | | | | Fax number: | | | |  | | | | | | | | |
| E-mail Address: |  | | | | | | | | | | | | | | | | |
| Medical Issue: | What was the medical issue an | | | | | | Illness? | | | |  | | Injury? | |  | | |
| If an injury, was it a | | | Motor Vehicle Accident? | | | | | | |  | | | | | | |
| If an injury, was it | | | Work related? | | | | | | |  | | | | | | |
| If an injury, was it | | | At someone’s home or business? | | | | | | | | | |  | | | |
| **Please give details below why Golden Cross assistance is needed**.  For example, what is your diagnosis and how long have you been ill. Attach with this form the bills related to this illness/accident you need our committee to consider.  We will be in touch with the applicant and/or the pastor when this form is received. | | | | | | | | | | | | | | | | | |
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| **Signature of Local Pastor, or Full Connection Clergyperson Date** | | | | | | | | | | | | | | | | | |
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| **Signature of Applicant Date** | | | | | | | | | | | | | | | | | |

E-mail completed application and attachments to:

Alina Crews, Administrator, Center for Congregational Excellence – [acrews@ngumc.org](mailto:acrews@ngumc.org)