



Associate Crisis Fund Request

Name: _____

Home Address: _____

Phone: _____ E-mail: _____

Department/Office: _____ Director: _____

Amount of Request: _____

*Please describe your situation and how you will use the requested funds.
(Attached supporting documentation, if applicable)*

I certify that I am employed by Hancock Regional Hospital or Hancock Physician Network. I have read the Associate Crisis Fund eligibility guidelines and I agree that the Foundation has the right to release my name and explanation of my hardship to the LIFT Committee or my Director to obtain assistance with my financial hardship as stated above.

Signature

Date