

CARE RELIEF FUND APPLICATION FOR ASSISTANCE Employees Helping Other Employees

	PLEASE TYPE OR PRINT LE	GIBLY – ALL IN	FORMATIO	N BELOW I	MUST BE P	ROVIDED	
Nam	e of Employee in Need						
Curre	ent Position						
Depa	rtment Name						
Nam	e of Person Making Request						
_ `	t the employee in need)						
Phon	e Number						
Amount Requested (Circle One)		\$100	\$200	\$300	\$400	\$500	
		ODANIT DEGUI		NO			
PLE	ASE CHECK ONE	GRANT REQUE	STOPIIO	NS			
	Natural Disaster, Fire, Flood	Assistance					
	Care of Family Member or Self						
	Transitional Housing						
	Relocation of Child(ren)						
	Emergency Travel						
	Funeral Expense						
	Other Please Describe						
Please describe the reason for the request and continue on the back or attach a separate sheet of paper. Please attach supporting documentation of extenuating circumstances and/or hardship to be considered for approval. Please note, when one person applies for another employee, the employee in need may be contacted for clarification.							

To request a copy of the guidelines please contact Human Resources.

Please submit completed application to:

Care Relief Fund

Attn: Human Resources
Western Missouri Medical Center
403 Burkarth Road
Warrensburg, MO 64093

Fax: (660)	747-8553				
Signature		Date	Date		
Grant Approved	GRANT REQUE	ST SELECTION COMMITTEE			
Amount of Grant	\$				
Grant Not Approved					
	•				
			<u> </u>		
Signature		Date			