Caregiver Assistance Application Form

Caregiver Name: Request Date:

Caregiver ID: Number of individuals in the home:

Home Address:

City: State: Zip:

Best Contact Information

Phone:

Email:

You will be notified by email of the decision made.

Director Name:

Your Leader will be notified during the application process. Please inform your leadership of this application to help the process move in a timely manner.

Amount Requested:

What is the need:

Please describe how COVID-19 has caused this need:

Please describe other resources applied for:

Approved ◯ Denied ◯

Approved ◯ Denied ◯

Approved ◯ Denied ◯

Approved ◯ Denied ◯

Approved ◯ Denied ◯

List the companies you would like assistance paying:

Name: Amount:

Name: Amount:

Name: Amount:

Name: Amount:

Please provide the current statement with this request.

Caregiver Signature

Email completed application to Natalie Willett: willettn1@covhs.org

COVID-19 Caregiver Assistance Committee Use Only:

Director Signature

Approved: ◯ **Denied:** ◯

Committee Member Signature

Committee Member Signature

Committee Member Signature

Foundation President Signature: