

## Tabitha S. Grier Medical Assistance Fund for UVA School of Nursing Alumni <u>Application</u>

Full Name:		
Complete Address:		
Phone Number:	E-mail Address:	
Last Four Digits of SSN:	Date of Birth:	
Nursing Class Year(s) and Degree(s):		
·	which may include but is not limited to: temporary or e, low or fixed income or permanent disability or the need cumentation)	
Briefly describe your current health circumst requesting financial assistance.	ances, conditions, or disease processes for which you are	
How does this condition impact on your abiliability to work, or otherwise contribute to fin	ity to care for yourself, provide for your basic needs, your anncial hardship?	

Grier Fund Application page 2	Name:	
Please describe any significan Medicaid, or other sources.	nt medical expenses you have that are not covered by insurance, Medica	are,
Specifically, how do you antic	cipate that you would spend any funding that you receive?	
assistive device or other treat	from your provider indicating your need for the medication, treatment, ment support for which you are requesting funding. (Please indicate bean documentation in a previous application)	
Signature of Applicant:	Date:	

Complete applications should be sent to:
UVA School of Nursing Alumni & Development Office
Grier Fund
P.O. Box 801015
Charlottesville, VA 22908-1015
(434) 924-0138