The United Methodist Church
ALABAMA-WEST FLORIDA CONFERENCE
Application for Aid through the GOLDEN CROSS FUND

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email address: _____

Spouse's Name: _____

Name of Local Church: _____

Pastor's Name: _____

Church Address: _____

Church City: _____ State: _____ Zip: _____

Phone Number: _____ Email address: _____

Name of Primary Physician: _____

City: _____ Phone Number: _____

Diagnosis: _____

Are you still under treatment? Yes ☐ No ☐

If YES, how long will treatment last? _____

INCOME INFORMATION

Job $_____ monthly

Unemployment $_____ monthly

Medicare (Disability) $_____ monthly

Medicaid $_____ monthly

Retirement $_____ monthly

Other $_____monthly

Signature of Applicant: _____ Date: _____

Signature of Pastor: _____ Date: _____

IT IS REQUIRED THAT YOU ATTACH A STATEMENT FROM THE HOSPITAL, PHYSICIAN OR PHARMACY OF PAST DUE AMOUNTS TO THIS APPLICATION.

SEND COMPLETED APPLICATION AND DOCUMENTS TO:

Mrs. Julie Terrell, RN
26610 Bridge Lane
Andalusia, AL 36421