



# COXHEALTH FOUNDATION

## APPLICATION FOR COXHEALTH COVID RELIEF FUND

If you have been adversely affected by COVID-19 or have a family member diagnosed with COVID19. You may apply for financial help. The HEROES fund is for those diagnosed WITH COVID -19, this fund is for those adversely affected by COVID-19 to the point of dire financial stress. What area has affected your family:

Explain your circumstance: \_\_\_\_\_

**\*\* Documentation REQUIRED: Copy of last pay check, recommendation from supervisor and bill or invoice from related expense.**

Once completed, email or fax your form to:

CoxHealth Foundation [chf@coxhealth.com](mailto:chf@coxhealth.com) or 269-9599

Children’s Miracle Network Hospitals [info@coxhealthcmn.com](mailto:info@coxhealthcmn.com) or 269-8818

### Questions?

Call 417-269-7150 / 417-269-6853

Monday – Friday from 8:30 AM – 5:00 PM

**Note:** Applications are reviewed as received.

Office Use Only
Approved Amount: \$ _____ Date: _____
Approved by: _____ & _____ Check Request Date: _____

### APPLICANT INFORMATION

Employee Name:	Employee ID#:	
Current Address:		
City:	State:	ZIP:
Email:		
Spouse’s Name:		
Number of Children Living at Home:	Ages of Children:	

### EMPLOYMENT/INCOME INFORMATION

Department:	Location:	Supervisor Phone Number:
Supervisor Name:	Hired: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	
Monthly Gross Income:\$	Social Security: \$	Unemployment: \$
Alimony: \$	Child Support: \$	Other Income: \$

