REQUEST FOR ASSISTANCE FORM

A CTDI employee may request financial assistance up to a maximum of $1,000 per year for himself/herself and/or his /her immediate family members who are suffering from cancer or other serious illnesses. **Please submit your completed form to CTDI_CARES@ctdi.com**

CTDI CARES MISSION STATEMENT

Our mission is to provide funding and support to CTDI employees or their immediate family members who are afflicted or stricken with cancer or other serious illnesses. Our goal is to lessen the financial burdens and to help CTDI employees or their immediate family members confront the challenges of cancer or other serious illnesses with determination and hope.

EMPLOYEE INFORMATION

NAME: _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

BRANCH: _____ **DEPARTMENT:** _____

EMAIL: _____ **HOME OR CELL NUMBER:** _____

HOW DID YOU HEAR ABOUT CTDI CARES? _____

BENEFICIARY INFORMATION

RELATION TO EMPLOYEE (Leave Blank if Applying for Yourself): _____

ILLNESS: _____ **AMOUNT REQUESTED:** _____

IF DEPENDENT, DOES THE BENEFICIARY LIVE WITH YOU? _____

Please be as detailed as possible with the reason for your request and what you will be using the funds for. Please note that, due to governmental regulations, we are unable to reimburse for medical expenses, co-pays or healthcare insurance premiums. Incomplete applications will cause a delay in processing.

_____

_____

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_____

_____

_____

SIGNATURE: _____ **DATE:** _____

FOR COMMITTEE USE ONLY

Date Received: _____ **Date Sent to Allocations Committee:** _____ **Approved (Y/N)** _____

Check Number: _____ **Check Amount:** _____