UNIVERSITY of VIRGINIA
SCHOOL of NURSING

Tabitha S. Grier Medical Assistance Fund
for UVA School of Nursing Alumni
Application

Full Name: _____

Complete Address: _____

Phone Number: _____ **E-mail Address:** _____

Last Four Digits of SSN: _____ **Date of Birth:** _____

Nursing Class Year(s) and Degree(s): _____

Describe your need for financial assistance which may include but is not limited to: temporary or permanent job loss, loss of health insurance, low or fixed income or permanent disability or the need for costly treatment. (Attach supporting documentation)

Briefly describe your current health circumstances, conditions, or disease processes for which you are requesting financial assistance.

How does this condition impact on your ability to care for yourself, provide for your basic needs, your ability to work, or otherwise contribute to financial hardship?

Please describe any significant medical expenses you have that are not covered by insurance, Medicare, Medicaid, or other sources.

Specifically, how do you anticipate that you would spend any funding that you receive?

Please attach documentation from your provider indicating your need for the medication, treatment, assistive device or other treatment support for which you are requesting funding. (Please indicate below if you have provided physician 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