



Request for Support

All information will be kept confidential

Contact Information

Name _____

Address _____

Email _____ Primary Phone Number _____

Best way and time to contact _____ Language Preference _____

What is your connection with events on 9/6/2011?

Please indicate all the ways you have been financially impacted, as well as any other ways not included below. *(During the review process, some documentation may be requested.)*

Loss of Income

Approx. wages lost to date \$ _____

Healthcare Expenses (Medical, Counseling, Etc.)

Approx. expenses to date \$ _____

Other Financial Impact

Childcare/Caregiver Expenses \$ _____

Funeral Expenses \$ _____

Other Expenses \$ _____ Please describe _____



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Would you like to receive information about coping and/or emotional support?

Do you have other needs or anything else you would like the Community Fund to know?

Thank you for taking the time to respond.

Email the completed form to kitty.mckay@ctrh.org

Fax the completed form to 775.888.6238

Drop off the completed form to the Carson Tahoe Foundation office located in the Specialty Medical Center (775 Fleischmann Way, Carson City, NV) during normal business hours.

**For questions or assistance in completing the application,
please call 775.445.5165.**

For Internal Use Only

By:

Review Date	Amount disbursed	Disbursement Method
		Disbursement Date