Compassion Fund Assistance Application

Member Information

Employee Name: _____

Employee ID: _____

Department: _____

Job Title: _____

Phone Number: _____

Email Address: _____

Home Address: _____

Request Information

Amount Requested: $_____

Date of Request: _____

Reason for Assistance

Please describe the hardship or emergency for which you are requesting assistance. *Include relevant dates, circumstances, and how the situation has affected you. Please use back of sheet if needed.

Member Signature: _____

Date: _____

Email completed form to compassion@nshorehc.com

***May be contacted by Committee for additional information and documentation of loss**

Revised 08.05.26