



SAN DIEGO FIRE RELIEF ASSOCIATION MEDICAL HARDSHIP GRANT ASSISTANCE REQUEST

Please fill out this form to help SDFRA assess your needs. When complete, please return the form to mnunes@sdfra.org. You will be contacted by SDFRA and may be asked to provide additional information to complete your assistance request.

PERSONAL INFORMATION

Requester Name: _____ Member ID: _____
Phone Number: _____
Address: _____ Email: _____
Date of Birth: _____ Marital Status: _____
Dependents & Age: _____

What best describes the individual seeking assistance:

Active Firefighter Retired Firefighter Dependent of Firefighter

PERSONAL INFORMATION

Please describe your situation and need for financial assistance including if there is an injury or illness that prevents working or reduced income, OR a significant expense used to treat or prevent further medical expenses due to the injury or illness.

Besides direct financial assistance, what other types of help could be beneficial to you? (i.e., meals, referrals etc.) Please describe:

Are you aware of the SDFRA's Medical Claim Reimbursement benefits?

Please list (or attach invoices if applicable) any specific expenses/medical costs.

Can you foresee any additional costs?

Applicant Signature: _____

Date: _____