**Form for Hospitals to Verify they have Reviewed and Determined Eligibility of Employees Who Meet Criteria  
FORM B – Submit to ReliefFund@ncha.org by Dec. 21**

Criteria for receipt of funds:

* Holds a primary residence located in one of the FEMA-designated disaster counties
* Sustained significant damage or loss of their primary residence as a result of Hurricane Florence
* Has been continuously employed for a minimum of 90 days prior to the loss or damage
* Is able to furnish proof of loss for insurance claim and/or application for FEMA assistance
* One Application per household

I do hereby certify that all submitted employees meet the eligibility criteria set forth by the North Carolina Hospital Foundation Disaster Relief Fund.

**Hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date request submitted:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CEO name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital mailing address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person completing request form:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list below the names of employees who completed FORM A on FORM C (excel spreadsheet)**

Please direct all questions to [ReliefFund@ncha.org](mailto:ReliefFund@ncha.org) or 919-677-2400