

# MICHIGAN NURSES FOUNDATION

RECOVERY SCHOLARSHIPS RESEARCH

## Recovery Financial Support Application

Name \_\_\_\_\_ Nursing/HC Professional License # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Personal Email \_\_\_\_\_

Employer \_\_\_\_\_ Unit \_\_\_\_\_

Last date worked \_\_\_\_\_ Est. return to work date \_\_\_\_\_

Current income: Self: \$\_\_\_\_\_/month Household: \$\_\_\_\_\_/month

Number of dependents\*\* \_\_\_\_\_

*\*\*relatives for whom you provide more than 50% of their support.*

Treatment Facility \_\_\_\_\_ Start date \_\_\_\_\_

Treatment Provider \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Contact Name \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Estimated Treatment Amount \$\_\_\_\_\_

Counseling \$\_\_\_\_\_ Lab \$\_\_\_\_\_ Processing \$\_\_\_\_\_

Amount covered by Insurance \$\_\_\_\_\_

Submit completed form to [contact@minursesfoundation.org](mailto:contact@minursesfoundation.org) or mail to:

Michigan Nurses Foundation, 2310 Jolly Oak Road, Okemos, MI 48864

5/18/2020