



IHERF Disaster Funds Request Form

Date Form Completed:

DISASTER INFORMATION

Name of Organization:
Date of Disaster:
Type of Disaster:

EMPLOYEE INFORMATION

Estimate of displacement time from home:
Estimate of Total Loss:
Insurance Coverage (yes or no):
If yes for insurance coverage, estimated out of pocket expenses:

CONTACT INFORMATION

Name:
Job Title:
Email Address:

If awarded, IHERF will address the check to the hospital or hospital's foundation. The hospital will then determine the distribution of funds to affected employees that have been displaced from their homes by the disaster.

Check Should Be Made Out To: _____ Address: _____

Hospital Administrator Signature: _____

*Subject to approval, including amount provided, of IHERF Board.

Contact Jennifer Nutt, Vice President, Nursing & Clinical Services
(nuttj@ihaonline.org) at 515-288-1955 with any questions.