



## HP FOR CONFERENCES – COPAY HARDSHIP WAIVER FORM

Date		
Conference Name		
Contact Name		
Contact Phone #		
Neighbor Requiring Assistance		
Amount of Request		
Required Copay		
Amount of Copay your Conference can provide		
Is the neighbor able to provide any funding?	Yes	No
Have you reached out to your District for funding?	Yes	No
Have you approached your conference to consider modifying guidelines to allow an exception for this neighbor?	Yes	No
Have you reached out to any community partners/agencies for funding?	Yes	No
If yes to the above, which partners/agencies?		
What challenge is preventing your Conference from meeting the copay requirements?		

Signed by Conference President:

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Printed Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Please submit the completed Hardship Waiver form **and your last Quarterly Report** to [HPReview@svd paz.org](mailto:HPReview@svd paz.org) for review.

HP/Conference Committee Review:

Approved

Not Approved

Reason: \_\_\_\_\_

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