KCDPC

Sponsorship Request/Offer Form

SPONSORSHIP REQUEST

Full name(s) of those requesting sponsorship for Kansas City Direct Primary Care membership fees:

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____

Primary contact email: Phone:

____ ______________________

Reason for request: ____

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____

This request is for __________ calendar months starting on ________/________/______________.
(NOTE: MAXIMUM OF 3 MONTHS AT THIS TIME)

How much are you currently paying for your KCDPC membership per month? $ __________/month

Of this, how much are you able to pay monthly, if anything? $ __________/month

I/Our family would like to request a scholarship to maintain our membership at Kansas City Direct Primary Care at this time. There is no guarantee we will receive a sponsorship. If granted, we understand that this scholarship covers the monthly membership fees but not ancillary fees like meds, labs, etc. If we wish to end our membership, a 30-day written notice will still need to be given per the terms of the KCDPC contract. Additionally, we understand that accounts 45 days overdue are closed and membership ends.

____ ________________

Signature Date

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SPONSORSHIP OFFER

Full name(s) of those providing sponsorship:

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Email: Phone:

____ ______________________

Amount: $__________ in one lump sum OR $__________ for ________ months

The undersigned understands that sponsorship will be provided to a person or family expressing need as detailed in the above application. This sponsorship is not tax-deductible and does not obligate the undersigned to future sponsorship. If the sponsorship fund goes unused at the end of the COVID-19 pandemic, excess funds shall be credited back to sponsors.

____ ________________

Signature Date

KCDPC STAFF USE: Received ___/____/____ by____________. Reviewed by ___________________________.
Scholarship request granted? NO *or* YES , $_________ for _________ months
Sponsorship offer accepted? NO *or* YES , $_________ lump sum or $______ for _____ months