Funding from the BCBS Community Pharmaceutical Care Fund will be considered for purposes such as:
- Transportation for students and faculty to reach underserved citizens
- Purchase of medication for those without the means to purchase essential medical items
- Medical supplies needed for health and wellness activities
- Food in cases where the lack of proper nutrition is part of a program for improving overall well-being

Person or group requesting reimbursement: _______________________________________________

Faculty member signature: ______________________________________________________________

Funding is requested for (describe the activity for which reimbursement from this fund should be considered and how this activity meets the needs of an individual or group deemed to be underserved or in need of assistance):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Amount requested: __________

Expedited review (approval for funding is needed within 30 days): Yes or No
If yes, please provide date approval needed by: __________

Benefit of activity for which funding is being requested (check all that apply):
Support of underserved family or individual: ____ Outreach opportunity: ____
Expanded service learning opportunity: ____ Research opportunity: ____
Improved access to care in underserved community: ____
Increased faculty expertise in developing community based and service-learning curricula: ____
Other: __________________________________________________________________________

Outcome measure (report status of achievement of outcome to the Clinical Services Committee):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Request approved: ____
Request denied: ____ Reason for denial: ________________________________________________

Request approved or denied by:

__________________________________                           ___________________________________
Clinical Services Committee representative               Clinical Services Committee representative

__________________________________                           ________________________________
Clinical Services Committee representative               Accounting (required for approved requests only)

** Submit all receipts for the use of funds and a copy of the approved request to the AUPCC for processing.**