EMPLOYEE EMERGENCY FUND FINANCIAL ASSISTANCE REQUEST FORM

All information is strictly confidential – Form Must Be Submitted via Email

(Please print and/or type clearly)

Employee Full Name: _____

Employee ID: _____ Date: _____

Hire Date: _____ Contact Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Purpose:
Grady Health System provides an Employee Emergency Fund for Grady Health System employees. The Employee Emergency Fund is maintained through the support of Grady Health System employees and other donations. Grady Health System & Grady Health Foundation is dedicated to helping employees in their time of true crisis due to unforeseen occurrences in the qualified areas listed below.

Eligibility:
All current full or part time employees on Grady Health System payroll in good standing with Grady Health System are eligible who have completed a minimum 90 days of service. Employment will be verified by Human Resources.

Examples of qualifying CONDITIONS that could trigger assistance through the Grady Health System Employee Emergency Fund:
- Natural disaster (flood, fire, tornado, etc.)
- Catastrophic injury or illness of self or immediate family member within the household
- Loss of a family member (immediate family - spouse, domestic partner, child, or parent)

Examples of qualifying EXPENSES (all must tie to qualifying Conditions):
- Funeral or travel costs
- Repair/replacement estimates, as applicable
- Hotel quote/lodging quotes/receipts, as applicable
- Medical bills (see policy for guidelines)

Examples of CONDITIONS that do NOT qualify:
- Personal financial management issues
- Financial hardships due to the loss of a household income or unexpected divorce
- Unexpected home repair issues
- Unexpected car repair issues
- Credit card debt
- Unexpected legal/attorney's fees
- Elective surgery

Examples of EXPENSES that do NOT qualify:
- Past due utilities, household bills, past due mortgage or rent, that are NOT associated with a qualifying hardship condition
- Automobile repairs, replacements or payments
- Routine medical bills
- Education costs

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Eligible employees must provide written, valid documentation of condition and expenses.

The documentation must be attached to the employee's request, and the employee's signature on the form grants authorization to Grady Health System Human Resources to contact and verify the source of the hardship.

The request and documentation must be submitted for review via email to GradyEmergencyFund@gmh.edu.

PLEASE INITIAL THAT YOU HAVE READ ALL REQUIREMENTS: _____

Please check which of these approved areas your financial emergency qualifies and for which you are able to document financial need:

- ☐ **Natural disaster (flood, tornado, etc.)**
- ☐ **Fire**
- ☐ **Catastrophic injury or illness**
- ☐ **Loss of a family member (**(immediate family - spouse, domestic partner, child, or parent)

Have you applied to the Employee Emergency Fund before? If yes, when and what was the reason?

The maximum assistance an eligible employee may receive is up to $1,000 or 5% of their annual pay, whichever amount is less, during any 12 month period.

Eligible employees are encouraged to use the Employee Assistance Program (EAP) (GHS Policy #300.05/EAP) to prepare to utilize the resources of this program in the best way. The EAP is the Grady Health System source for confidential connection to resources for personal challenges of any magnitude.

MUST FILL OUT BOTH SECTIONS BELOW TO BE CONSIDERED

SPECIFIC CONDITION CAUSING HARDSHIP (ALL SUPPORTING DOCUMENTATION SUCH AS FUNERAL NOTICES, POLICE REPORTS, DOCTORS NOTES, MUST BE ATTACHED AND CAN BE VERIFIED)

SPECIFIC EXPENSES ASSOCIATED WITH THE HARDSHIP (ALL SUPPORTING DOCUMENTATION SUCH AS RECEIPTS, BILLS AND/OR ESTIMATES MUST BE ATTACHED AND CAN BE VERIFIED)

Total Amount Requested: _____

Should a grant be approved, which creditor(s)/vendor(s) should receive a check by postal mail (space for 2 to be listed here, please submit additional forms for additional creditors):

Creditor Name **(1)**: _____

Address: _____

City: _____ State: _____ Zip: _____

Creditor Account Number: _____

Creditor Account Name Listed Under: _____

Creditor Amount to be paid: _____

Creditor Name **(2)**: _____

Address: _____

City: _____ State: _____ Zip: _____

Creditor Account Number: _____

Creditor Account Name Listed Under: _____

Creditor Amount to be paid: _____

My signature below grants authorization to Grady Health System Human Resources to contact and verify the source of the hardship. I fully understand providing false information in connection with my request for financial assistance is subject to corrective action up to and including discharge in accordance with Grady Health System employee relations policies. A completed W-9 must accompany this application if it is for $600.00 or greater.

I have read and completed the application based on the policy guidelines. **I understand an incomplete application without valid documentation may not be considered.**

_____ _____

Employee's Signature Date

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Grady Health System Official Use

Employee Emergency Advisory Committee application decision

Approved _____ **Declined _____**

Notes:

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