Associate Emergency Assistance Fund Application

Dear OhioHealth Associate,

Your OhioHealth colleagues are concerned about your well-being and have generously donated to the Associate Emergency Assistance Fund to help. If you have recently experienced a catastrophic life event resulting in a financial hardship, you may be eligible for assistance.

The process is strictly confidential and the attached forms are used to help the Associate Emergency Assistance Fund Committee determine your eligibility for assistance.

It is important to understand that this fund is for financial hardships caused by either:

1) **Unexpected catastrophic situations such as a fire, robbery, family death, etc. or**
2) **Unexpected catastrophic medical expenses not covered by insurance**

Before you fill out this packet please understand the following program parameters:

+ There must be a specific event that has caused the need for your request.
+ You must be employed at OhioHealth (Full or Part Time status) for a minimum of one year and have no current performance or attendance issues. Your manager will be contacted to verify this.
+ You may apply to the fund no more than **once (1) per 12 month period or four (4) total times** in your career with OhioHealth regardless of the outcome of your application(s). If granted a loan, re-application is not permitted within 12 months of loan repayment.
+ Households with >1 associate may not submit or have multiple active applications and/or loans at the same time.
+ **INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED - NO Exceptions!** Whenever possible, please include copies of documentation (i.e. statement copies) for each vendor you list on the "Specific Bills I want Assistance with Page" of the application
+ The limit of the fund's assistance is $2,000. For Medical catastrophic situations the amount will be equal to 60% of the maximum out-of-pocket expenses or $1,500/Associate, $2,250/ Associate plus 1 or $3,000/Family)
+ Assistance is usually granted in the form of a no-interest loan which is repaid through payroll deduction over the course of 9-12 months depending on the loan amount. In rare instances, a "Gift" is granted.
+ The fund cannot to be used for long term financial or car repair problems. It is to be used only as a **"last resort"** measure after all means of trying to obtain financial help are exhausted.

Have you done the following?

+ Contacted family and friends for financial support?
+ Contacted the Credit Union or bank for a loan?
+ Contacted your physician or hospital billing department to adjust payments?

You may also want to consult the following community resources:

+ First Link – Call 211 (This resource can link you with agencies for food, clothing and medications and housing)
+ Consumer Credit Counseling – (614) 464.2227
+ Franklin County Jobs and Family Services – (614) 462.4000
+ Patient Financial Services at Grant/Riverside – (614) 566.3911 (which can help with any hospital bill/charges)
+ The Employee Assistance Program (EAP) – (614) 566.3348 (which can provide you with counseling and support)
+ Religious organizations that you may belong to.

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How to apply to the Emergency Assistance Fund – *Page 2 of 5*

Step 1 –
Complete the forms attached entirely. The committee must have all the current financial information to process your request. **Remember all of this information will be kept confidential.**

Step 2 – Fax, email or mail your completed form to:
Associate Advocacy Center, Human Resources
David P. Blom Administrative Campus (BAC)
3430 OhioHealth Parkway
Columbus, Ohio 43202
Phone (614) 533.8172
Fax (614) 566.6942
Email: AdvocacyCenter@ohiohealth.com

Step 3 –
Your completed request form (pages 3, 4 & 5) **with documentation** must be received by Monday, 4 p.m., to be considered for that week's committee meeting. (*Medical requests must include copies of invoices).

Step 4 –
The Associate Emergency Fund Committee will review all requests. A check request will then be forwarded onto Accounts Payable for those that are approved. The committee will recommend that the monies distributed will either a "loan", where an associate will payback (interest free) through payroll deduction or be a "gift" that the associate need not payback.

Step 5 –
Applicants will be notified on Wednesday of the outcome of the committee's review. It is not necessary to contact our office prior to Wednesday to check the status.

Step 6 –
If approved, all checks will be made payable to whom you owe. Loan documents and checks will be available the Monday of the following week. It is the associate's responsibility to come in person to Human Resources to complete the loan documents, pick up the check(s), and deliver/mail them to their creditors.

Associate Emergency Assistance Fund Request Form – *Page 3 of 5*

(Please print clearly and complete all sections)

Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone _____ Campus_____

Department_____ Job Title_____

Hire Date _____ SS#_____

Scheduled Hours_____ Shift_____ Clock #_____

Have you applied to the fund before? ❒ Yes or ❒ No If yes, when_____

Name of Supervisor_____ Phone #_____

Is it okay for the Emergency Assistance Fund Committee to contact your supervisor? ❒ Yes or ❒ No

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Give a brief description of the **specific catastrophic event** that caused the financial need:

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For Committee Use Only:

_____ _____ _____ _____

FINANCIAL INFORMATION – *Page 4 of 5*

1. ASSETS – CHECKING AND SAVINGS ACCOUNTS:

Institution and Account Number	Checking	Savings	Present Balance

YOUR HOURLY WAGE $ _____

Residence	Payment/Month	Mortgage or Rent Payable to:
❒ Rent ❒ Own		

2. LIST ALL BILLS AND VENDORS YOU TYPICALLY OWE EACH MONTH:
(If more space is needed, use the reverse side of this form)

Creditor's Name	Acct. # and Payment/Mo	Balance	For what?

3. SPOUSE INFORMATION (If applicable)

Name_____

Present Address_____

Employer _____

Yrs. Employed _____ Gross Salary_____

Weekly/Monthly_____

4. DEPENDENT INFORMATION (If applicable)

Number of dependents _____ Ages _____

Any other source of income _____ Amount _____

5. OTHER INFORMATION

Have you **ever** filed for bankruptcy? ❒ Yes ❒ No If Yes, when?_____

Are you considering filing for bankruptcy?_____

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Specific Bills you would want assistance with – *Page 5 of 5*

****Be sure to submit "official" company name, address, amount owed, your account #, and any documentation you might have. If approved, Check(s) will be made payable to:**

1. Name of Creditor_____

   Amount Owed_____ Account Number_____

   Address _____

   City_____ State_____ Zip_____ Phone Number_____

2. Name of Creditor_____

   Amount Owed_____ Account Number_____

   Address _____

   City_____ State_____ Zip_____ Phone Number_____

3. Name of Creditor_____

   Amount Owed_____ Account Number_____

   Address _____

   City_____ State_____ Zip_____ Phone Number_____

4. Name of Creditor_____

   Amount Owed_____ Account Number_____

   Address _____

   City_____ State_____ Zip_____ Phone Number_____

5. Name of Creditor_____

   Amount Owed_____ Account Number_____

   Address _____

   City_____ State_____ Zip_____ Phone Number_____