SINGING RIVER HEALTH SYSTEM FOUNDATION

Employee Relief Fund

Application for Assistance Instructions

Singing River Health System Foundation is proud to offer the Employee Relief Fund which assists Singing River Health System employees with short-term financial assistance during unexpected and unavoidable emergencies causing a financial burden. Employees are eligible to apply under multiple circumstances, however all other available resources such as insurance, disability coverage, savings and local assistance programs should be used before applying for emergency assistance from Singing River Health System Foundation. Any assistance the Foundation may provide is usually limited to one recipient per household.

The following guidelines, while not all inclusive, are provided to assist the employee in determining if it is appropriate to request assistance from Singing River Health System Foundation. Please complete the application in its entirety and provide any documentation of the need for assistance. Incomplete applications will be returned.

The application will be reviewed by the Singing River Health System Foundation Executive Director and the Singing River Health System Foundation Board of Directors as soon as possible. Once a decision has been made for approval or disapproval you will be notified. Please allow 3-4 business days for a decision to be made.

Email, mail, or fax the completed application to:

Laura Sessum
Executive Director
Singing River Health System Foundation
3109 Bienville Blvd, Ocean Springs, MS 39564
Phone: 228.818.4011
Fax: 228.818.4014
Laura.Sessum@mysrhs.com

Employee Relief Fund Guidelines

Expenses that will be considered

- Home Catastrophe/Natural Disaster
    - Personal residence is destroyed or rendered unlivable by a natural disaster, including hurricanes, tornados, or fire. Funds will not be distributed to individuals merely because they are victims of a disaster; there must exist a financial need.
- Funeral Emergency Travel Expenses
    - Employees who have incurred the loss of an immediate family member (spouse, sibling, children, step-children, parents, grandparents, and in-laws) and the employee can demonstrate significant financial difficulty paying for emergent travel expenses to attend the funeral.
- Personal or Medical Emergency
    - Employees who have encountered financial hardships for reasons beyond their control, such as a medical emergency, and all other resources have been exhausted.

Expenses that will NOT be considered

- Longstanding financial problems not related to a specific event do NOT meet the criteria of the fund.
- Credit card debt, discretionary or elective bills such as cable television and cell phones, child support, attorney fees, garnishments of an employee's paycheck for any reason, or past due monthly bills of a similar nature **do not** meet the criteria of the fund.

Maximum grant size is usually limited to the lesser of the need or $1,000.

SINGING RIVER HEALTH SYSTEM FOUNDATION

Application for Emergency Assistance
EMPLOYEE

Please print clearly.

Date Submitted:

Employee Name:

Amount Requested:

Employee Date of Birth:

Employee SSN:

Employee Address:

_____

_____

_____

Other Assistance: (Red Cross, United Way, family, food stamps, etc.)

Source _____

Amount _____

Source _____

Amount _____

Employee Phone:

Work _____

Home _____

Cell _____

Employee Department:

Facility _____

Length of Employment _____ yrs. _____ mo.

Director _____

Director's Phone _____

Income:

Employee Salary - before deductions - $ _____

○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly

Employee Salary - after deductions - $ _____

Spouse Salary - before deductions - $ _____

○ hourly ○ weekly ○ bi-weekly ○ monthly ○ yearly

Spouse Salary - after deductions - $ _____

Other Income: (social security, VA, workman's comp, retirement, child support, etc.)

Source _____

Amount _____

Source _____

Amount _____

Source _____

Amount _____

Source _____

Amount _____

Dependents:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Banking Information:

Checking Balance _____

Bank _____

Savings Balance _____

Bank _____

Other Balance _____

Source _____

Other Balance _____

Source _____

Housing Expenses:

Own - mortgage payment $ _____

Rent - monthly payment $ _____

Other Monthly Expenses: Cable $ _____

Utilities $ _____ Food $ _____

Clothing $ _____ Vehicle $ _____

Cell $ _____ Misc $ _____

Creditors:

Name	Monthly Pmt	Balance

Total Combined Income: _____

Total Combined Assets: _____

Total Combined Expenses: _____

Describe your emergency and specific needs, in detail. Please attach supporting documentation, such as your pay stub, pharmacy bill and other invoices.

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Singing River Health System Foundation to verify this information. I understand any intentional false statements will be considered an attempt to commit fraud upon the Singing River Health System Foundation and may result in denial of my request for assistance. Additionally, I authorize the Singing River Health System to disclose any confidential and/or financial information to the Singing River Health System Foundation Board of Directors as it pertains to the above emergency. I further authorize the Singing River System Health Foundation and the Singing River Health System Human Resources Department to disclose any confidential and/or financial information to other community agencies (i.e. Red Cross, United Way) to determine if I am eligible to receive assistance from such agency.

Signature of applicant: _____ Date: _____

FOR FOUNDATION USE ONLY

Date:	○ Approved ○ Denied
Comments:	
Signature:	