SAINT FRANCIS MEDICAL CENTER FOUNDATION

Confidential Application

INSTRUCTIONS: This confidential information form is used in processing your Employee Caring Fund request. Be sure to complete each section fully and accurately to ensure prompt attention to your application.

1. **Identification Data: (Please print)**

   Name _____Address_____

   City _____ State _____ ZIP _____

   Phone # _____ Employee ID # _____

   If overtime hours are available, how many do you usually work? _____

2. **Previous Caring Fund Use**

   Have you applied to the Caring Fund in the past? Yes No

   If yes, what was the date of the application? _____

   Did you receive funds? Yes No

3. **Reason for Emergency or Crisis:** Give reason assistance is needed.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

4. **Members of Household: (List all persons living with you.)**

	Name	Age	Sex M	Sex F	Attend School? Yes	Attend School? No
1.						
2.						
3.						
4.						
5.						

5. **Income/Expenses: (Please list income and expenses for all persons in household)**

Monthly Income: (Net Pay)

Remaining
Self $_____

Self (2nd Job) $_____

Spouse $_____

Spouse (2nd) $_____

Children $_____

Roommate $_____

Child Support $_____

Alimony $_____

Retirement $_____

Disability $_____

Aid for Dep. Children $_____

Food Stamps $_____

Other: (Workers Compensation)

_____ $_____

_____ $_____

Subtotal $ _____

Other Assets:

Savings Accounts $_____

CDs, Credit Unions $_____

Stocks, Bonds, etc. $_____

INCOME TOTAL $_____

Monthly Expenses:

Name of Company	Monthly Amount Due	Past-due Amount	Balance
Rent			
House Pymt			
Utilities			
Phone			
Food			
Credit Cards			
Gas			
Auto Loan			
Auto Loan (2)			

Insurance:

Home			
Health (List only if not on SFMC Health Plan)			
Vehicle			
Other Loans			
Child care			

EXPENSE TOTAL $_____

6. **Medical Bills/Insurance Information**

Are you enrolled in the Medical Center insurance? Yes No

If so, which plan are you enrolled in? _____

Have you met your deductible this year? Yes No Remaining Amount $_____

Medical Doctor Bills _____

Other Hospital Bills_____

7. **Illness** (If illness is involved, please list:) _____

_____

Hospitalization date(s) _____

Physician(s) _____

Time off work (dates) _____ Date due to return to work _____

8. **Amount Requested: $_____ If approved, what are the most critical bills to be paid?**

Pay to: _____ Amount: $_____

_____ $_____

_____ $_____

*Please provide copies of bills for above requested support for review. Checks will be directly sent to creditors.

9. **Efforts to Seek Other Financial Assistance: (e.g. friends, family, church, community resources, etc.)**

_____

_____

Have you contacted the Employee Assistance Program (EAP)? Yes No Not Applicable

Will you contact EAP? Yes No

10. **Other Comments** _____

_____

_____

11. **Statement of Agreement**

I agree to accept Saint Francis Caring Fund assistance. I certify that the information is true and correct to the best of my knowledge. I understand and agree that Human Resources may check my personnel file before making a decision. In addition, Saint Francis Patient Accounts may be contacted as necessary. I further understand that any assistance given does not have to be paid back unless I so desire. If I violate the confidentiality agreement I realize I will not be eligible to apply again for a period of five years.

I agree to hold the amount of funds received and my personal situation in confidence.

Name (please print): _____ Date: _____

Signature: _____

The Caring Fund Committee would like to remind you of the Employee Assistance Program (EAP). This is a free, confidential counseling service for you and your family to call anytime: 800-765-9124.

Caring Fund Committee Use Only

☐ Approved ☐ Denied Reason:_____

Application #: _____