**CHRISTUS Health Associate Relief Fund Application**

The CHRISTUS Health Associate Relief Fund provides financial assistance to CHRISTUS Health Associates who are experiencing personal short-term financial hardship due to a tragedy, disaster, or other extreme life event. Completed applications are reviewed by the Associate Relief Committee to determine eligibility for assistance.

Any CHRISTUS Health Associate meeting the qualifications listed below is eligible to apply for assistance. To ensure all Associates have the same opportunity to access relief funds, family members of Associates are not eligible for assistance. The maximum amount an Associate may receive from the CHRISTUS Health Associate Relief Fund is $1,000.

To be eligible for consideration for assistance, the Associate must:

1. Be an Associate of CHRISTUS Health.
2. Have not received assistance from the fund within the past 12 months and no one else in the same household has received assistance from the fund within the past 12 months.
3. Have recently (within the immediate past 60 days) been, through no fault of their own, subject to an act of God or other significant catastrophe or crisis, which is currently, after reasonable efforts at mitigation, causing significant, documentable hardship, financial or otherwise, to the Associate and their immediate family.

**Application**: To be considered for assistance, complete all areas of the application. Answering questions completely will help us process your request quickly.

* Attach current bills, invoices, and supporting documentation.
* Completed applications should be delivered associaterelieffund@christushealth.org.

**SECTION 1: INFORMATION ABOUT YOU**

***Note: All information contained in this application is confidential and will not be shared.***

|  |
| --- |
| Employee Name: Click or tap here to enter text. |
| Home Address: Click or tap here to enter text. |
| City: Click or tap here to enter text. | State: Click or tap here to enter text. | Zip: Click or tap here to enter text. |
| Contact phone:Click or tap here to enter text. |
| Have you applied to this program before? [ ] Yes [ ] No | If so, when? Click or tap here to enter text. |
| Work Location: Click or tap here to enter text. | Department: Click or tap here to enter text. |
| Hire Date: Click or tap to enter a date. | Job Title: Click or tap here to enter text. | Associate ID#: Click or tap here to enter text. |

**SECTION 2: DESCRIBE YOUR SITUATION**

Which qualifying incident caused your current financial hardship:

[ ]  Natural Disaster [ ]  Serious Illness or Injury [ ]  Death in Family [ ]  Catastrophic or Extreme Circumstances

Detail of incident: Click or tap here to enter text. Date of incident: Click or tap to enter a date.

*Tornado, flood, type of illness or surgery, deceased’s name & relationship, name of circumstance, etc.)* *(must be within 90 days of application)*

Was the incident covered by insurance? [ ]  Yes [ ]  No

If yes, is your application today being submitted after insurance coverage has been applied? [ ]  Yes [ ]  No (If no, why not?)

Click or tap here to enter text.

Describe what happened that caused your financial hardship:

Click or tap here to enter text.

Please tell us anything else you feel would help us understand the hardship you and your family are experiencing as a result of this incident:

Click or tap here to enter text.

**SECTION 3: SPECIFIC REQUEST**

Associate Relief funds are paid to vendors in response to an unpaid bill or invoice for eligible, basic expenses. Examples of eligible expenses:

* Rent, mortgage or other housing payments
* Temporary housing and security deposits for new housing
* Utility bills (electricity, heating, water, etc.)
* Medical expenses not covered by insurance, including needed equipment
* Home repairs or services necessary to restore or maintain safety
* Funeral expenses for immediate family (as defined by Magellan’s bereavement policy)
* Car repairs (if company requires you to use your personal vehicle in the course of your job duties)

**Payment**: If an application is approved, payment(s) will be made through payroll to the Associate.

**SECTION 4: ESSENTIAL PROGRAM INFORMATION**

An application does not guarantee fund support. If awarded, the fund support you receive is not considered an employee benefit. Applications are assessed without regard to your work evaluation or position within the company and will not impact your employment in any way.

Your signature below signifies that you understand the paragraph above, that only one application for support can be filed in a calendar year (except in extraordinary circumstances), that the annual maximum that you can request is $1,000, and that support may be below this amount.

Your signature below also certifies that the information you provided is true and complete, releases CHRISTUS Health Foundation from any liability associated with the denial of or funding of this application, and authorizes the Foundation to verify information provided in connection with processing this application.

Signature: Click or tap here to enter text. Date: Click or tap to enter a date.

**Before you submit, complete the Application Checklist for your own peace of mind:**

[ ]  I read the requirements and I feel that I qualify.

[ ]  I completed Sections 1, 2 and 3 with all the details requested.

[ ]  I read Section 4 thoroughly, and signed and dated my application.

[ ]  I am keeping a copy of my application for my file.