Request for Employee Assistance – Checklist

Please read and check before completing the application.

IMPORTANT:

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED. SUPPORTING DOCUMENTS AND VERIFICATION OF CRITERIA AND CREDITORS TO BE PAID MUST BE INCLUDED. PLEASE BE AS SPECIFIC AS POSSIBLE.

☐ **I have completed the application in full. All blanks are completed. All questions are answered.**

I meet the following criteria that have threatened my ability to pay expenses:

☐ Natural Disaster (Fire, Flood, Tornado, or Hurricane)
☐ Severe illness of a household member, with hospitalization or intensive medical assistance
☐ Death of an immediate family member
☐ Domestic Violence

☐ I included documentation supporting my criteria claim as follows:

- Natural Disaster
  Fire – Fire Marshall's Report, Fire Insurance Claim
  Flood or Severe Storm – Pictures, Insurance Claim, Newspaper Article
- Severe Illness of Household Member
  Hospital Report or Bill/ Letter from Physician
- Death of an Immediate Family Member
  Funeral Service Bill/ Obituary
- Domestic Violence
  Proof of Statement from Agency/Supporting Documentation from Physician/Social Worker

☐ I included the bills related to shelter or medical services for which I need assistance:

- Rental Agreement or note from Landlord with contact information
- Mortgage payment coupon
- Utility Bill
- Medical Bill

☐ I checked one of the boxes on the page five concerning the General Release. An application cannot be processed without one box being checked.

Please return to the following:

The Guardian Elder Care Foundation
Email: Foundation@guardianeldercare.net Fax: (814) 265-1796, Attn: Foundation

The information you provided on this application is considered confidential by the Guardian Elder Care Foundation and will only be shared with other parties as necessary to process your request or as you give us permission. Monies are disbursed to creditors, not applicants. If no creditor exists, no money will be awarded.

Request for Employee Assistance

(Please Print)

Name:____ SS#:_________________________

Address:____
(Street Name or PO Box)

____
(City) *(State)* *(Zip Code)*

Telephone No.:(______)________________________________ (______)____________________
(Home) *(Work)*

Organization You Work For:____

Dept. /Title:_____________________________________ Date Hired:_______________________

Are you currently able to work? Yes No
If No, how long have you been unable to work?______________________________________

Marital Status (circle one): Married Single Divorced Widowed

Age: ______________

Please list **ALL** people residing in your household (not including self):

Name	Age	Relationship

Criteria Met:

- ☐ Natural Disaster
- ☐ Severe Illness
- ☐ Death of Immediate Family Member
- ☐ Domestic Violence

8796 Route 219, VSI Building, Brockway, PA 15824 Phone: 814-265-7886 Fax: 814-265-1796

Monthly Expenses:

Food:	$____________	Utilities:	$____________
Car/Truck:	$____________	Other:	$____________
Rent/Mortgage	$____________	Other:	$____________

TOTAL MONTHLY EXPENSES: $____

Monthly Income:
(Supporting documentation is required: copy of paystubs)

Yourself:	$____________	Spouse:	$____________
Child Support:	$____________	Other:	$____________

TOTAL MONTHLY INCOME: $____

Do you currently have any money in a savings account: Yes No
If Yes, how much? $____________ Other accounts? $____________

Housing (circle one): Renting Buying Other

Are you currently behind on your payments? Yes No How Much? $____________

Amount of assistance needed: $________________ *(Maximum request is $2,500)*
(Supporting documentation is required: copies of bills, invoices, statements, etc.)

Assistance needed by (date): ________________________

Has there been a prior request to Guardian Elder Care Foundation? Yes No
If Yes, please list date, amount, and reason:

Date:______________________ Amount:____________________

Reason:____

Nature of Emergency. *(What caused the need?)* Please be detailed and include dates:

____

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____

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Please list what the money will be used for. (Examples: medical attention, utilities, house payments, etc) Please provide proof such as a copy of bills, payment coupons, etc.:

____

____

____

____

Have you sought help from other sources: Yes No

If Yes, please describe:____

____

____

____

Has your facility/office provided you with any type of assistance? Yes No

If Yes, what type and how much?____

____

Is there a contact person who has personal knowledge of your situation? Yes No

If Yes, please provide name and telephone number:______________________________

____

As stated on page one of the application, it is our policy to remit payment to the creditor. Payment will not be made to the applicant. Please give the name and address of the creditor to whom the debt is owed. If no creditor exists, no monies will be disbursed.

Name of Creditor ____

Address of Creditor ____

____

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IMPORTANT:

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED WITHOUT **ALL** SUPPORTING DOCUMENTATION. IF SUPPORTING DOCUMENTATION IS MISSING, THE PROCESSING OF THE APPLICATION **WILL BE** DELAYED. PLEASE BE AS SPECIFIC AS POSSIBLE.

By signing below you are verifying the information provided on this application is true and accurate to the best of your knowledge. You are also giving permission for a Guardian Elder Care Foundation representative to speak to a contact listed above. You are also stating that you have read the Guardian Elder Care Foundation Guidelines and fully understand all eligibility requirements.

The information you provide on this application is considered confidential by the Guardian Elder Care Foundation and will only be shared with other parties necessary to process your request or as you give permission.

____ ________________________
Employee Signature Date

General Release of Information

Recipient
(One of the following boxes MUST be checked in order to process the application.)

- ☐ The Foundation may use my name and story to help promote its mission.
- ☐ The Foundation may use my story but not my name to promote its mission.
- ☐ The Foundation may not use my name or my story to promote its mission.

____ ________________________
Signature Date

8796 Route 219, VSI Building, Brockway, PA 15824 Phone: 814-265-7886 Fax: 814-265-1796

The Selection Committee meets the last Wednesday of every month to review applications that are received. Please have your application remitted five (5) business days prior to the last Wednesday of the month. Any applications not received by the five business day deadline, will be reviewed by the committee the following month.

Please scan to:
Foundation@guardianeldercare.net

Please fax to:
Guardian Elder Care Foundation
(814) 265-1796

Or mail to: (last resort – much slower process)
Guardian Elder Care Foundation
Attn: Lori Hultman
8796 Route 219
VSI Building
Brockway, PA 15824

Please call (814) 265-7886 for questions or more information. Call toll free at (888) 880-7090.

FOR OFFICE USE ONLY

Approved (include amount):____

Denied:______________ Reason:____________________________________

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