Cape Cod Healthcare Employee Hardship Program
Application for Assistance

(To be submitted to the Cape Cod Healthcare Foundation Office, c/o Beatrice Gremlich, P.O. Box 370, Hyannis, MA 02601 or via email to: bgremlich@capecodhealth.org)

Applicant Information

Last Name	**First Name**
Street Address	
City, State, Zip	
Phone Number	**Email Address**
Relationship to Beneficiary ☐ Self ☐ Co-Worker ☐ Family Member	**Applicant Employment Information** CCHC Entity: Job Title: Employment Status: Hire Date:

Beneficiary Information (if other than Applicant)

Last Name	**First Name**
Street Address	
City, State, Zip	
Phone Number	**Email Address**

Acknowledgements

Please initial the statements below.

_____ I understand that Cape Cod Healthcare will take reasonable measures to protect my privacy. However, I understand that my anonymity cannot be guaranteed.

_____ I understand that funds may not be available at this time and that my application does not guarantee approval of funds.

_____ I have provided supporting documentation and agree to provide additional information that may be requested by the Fund Review Committee.

Reason for Application

The Beneficiary has experienced the following:

☐ Death of employee or family member
☐ Severe illness or accident
☐ Uninsured losses caused by fire, crime, or other disaster
☐ Other

Please provide any information to help the Fund Review Committee make a decision. Please note that you are not required to provide personal information that would prove embarrassing or cause added emotional stress. This section should serve only to clarify your situation and support your application. Attach additional pages if necessary.

You are required to substantiate your incident. Please attach documentation associated with the reason for the application. This may include but is not limited to:

- Certification of medical condition
- Death certificate
- Obituary
- Medical bills
- Insurance claims
- Police reports
- Expense receipts
- Foreclosure or eviction notice
- Any outstanding bills intended to be paid with Hardship Assistance award

Is there insurance that would help in this situation?

☐ Yes ☐ No

If yes, has a claim been submitted?

☐ Yes ☐ No

Describe how the incident prevents you from meeting your financial obligations.

Personal Finances

Because the Fund is limited, applicants should seek assistance from other sources before applying for Fund assistance. Applicants must demonstrate a temporary financial hardship that cannot be met by other means and is caused by a qualified incident. To assist with the evaluation of each request, applicants must submit personal finance information that shows a picture of the family's finances.

Your Assets/Values: (what you own)

Cash/Savings	$_____
Real Estate	$_____
Vehicles	$_____
Retirement Funds	$_____
Total	**$_____**

Your Liabilities: (loan balances)

Real Estate/Mortgage	$_____
Vehicles	$_____
Outstanding Bills	$_____
Other Debt	$_____
Total	**$_____**

Your After Tax <u>Monthly</u> Household Income:

	Prior to <u>Hardship</u>	**<u>Current</u>**
Your Monthly Wages	$_____	$_____
Spouse's monthly wages	$_____	$_____
Child support received	$_____	$_____
Disability insurance	$_____	$_____
Social Security/Pension	$_____	$_____
Other Income	$_____	$_____
Total	$_____	$_____

Your <u>Monthly</u> Living Expenses:

Rent/Mortgage	$_____
Utilities	$_____
Food	$_____
Child support owed	$_____
Medical expenses	$_____
Car loans	$_____
Gas/Incidentals	$_____
Other	$_____
Total	**$_____**

Amount of Assistance Requested

Amount: $_____ (maximum request = $2,500)

What the funds will be used for: _____

Applicant Signature: _____

Date: _____

For Fund Review Committee Use Only

☐ Approved
☐ Not Approved

Cape Cod Healthcare Employee Hardship Fund
Donation Form

(To be submitted to the Cape Cod Healthcare Foundation Office, c/o Beatrice Gremlich, P.O. Box 370, Hyannis, MA 02601 or via email to: bgremlich@capecodhealth.org)

Donor Information

Last Name	**First Name**
Street Address	
City, State, Zip	
Phone Number	**Email Address**
If you are an employee, please provide your employee number:	

Donation

Type of Donation

☐ I wish to make a donation in the amount of $_____

- ☐ Cash enclosed
- ☐ Check enclosed (make check payable to: Cape Cod Healthcare Foundation)
- ☐ I would like to make my donation through payroll deduction
  - ☐ Please deduct my donation amount through one single payroll deduction; or
  - ☐ Please deduct my donation through payroll deduction each pay period

☐ I wish to donate available vacation hours* in the amount of _____ hours

*Donation of vacation hours cannot exceed 40 in a calendar year.

Acknowledgement

Please read and sign below

I understand that my donation cannot be earmarked for a specific individual(s) and that any donation of my vacation hours will be treated as taxable income.

Signature: _____

Date: _____