Providence Foundation

Providence Foundation Employee Assistance Application

The purpose of the Providence Foundation Employee Assistance Fund is to provide emergency financial assistance to USA Health Providence Hospital employees experiencing a crisis due to circumstances beyond their control. This is a confidential process and is based on need documented with receipts or bills that cannot be paid due to life changing events.

In order to qualify, the employee must meet the following criteria:

- Employees must work a minimum of 20 hours per week
- Employees must have been a USA Health Providence Hospital employee for at least 90 days
- Bills and other supporting documentation must be in the associate's name and contain their home address on record
- Employees must submit supporting documentation highlighting their need, along with their last two pay stubs
- Additional documentation requested must be submitted within seven days
- Employees must earn less than $52,035 annually

Please note that assistance is not immediate. This request will be reviewed and kept confidential and determination will be made as to meeting criteria for need. We do not make checks payable to an associate but will work with you towards payment to a landlord, utilities, etc.

Please complete all questions on the application

Employee Information

Name: _____

J#: _____ Application Date: _____ Hire Date:_____

Hours Worked Weekly: _____ Number of Children and Ages: _____

Address: _____

Mobile Phone: _____ Work Phone: _____

Email: _____DOB: _____

Department: _____ Manager Name: _____

Supervisor Phone: _____ Supervisor Email: _____

Hardship Information

1) Please describe in detail what circumstances have occurred that resulted in your hardship? (Be very specific to avoid delays in review of your application. Include any documentation necessary to support your case.)

_____

_____

_____

_____

_____

_____

2) What are you needing assistance with?

_____

3) What is the amount you are requesting? $_____

(Please note that assistance may be approved for a maximum of two requests per employee per calendar year in an amount not exceeding $1,000 in total. A maximum of $2,000 can be granted for extenuating circumstances)

4) Is this your first request under the Providence Foundation Employee Assistance Fund?

_____

5) Have you lost any work time for which you were not paid? _____

Length of absence: _____ PTO used during absence: _____

PTO Balance: _____

6) Have you lost any work time for which you were not paid? _____

If so, how much? _____

I authorize the representatives of the Providence Foundation Employee Assistance Committee to receive information pertaining to my request and release appropriate information that would assist the evaluation of my application for financial assistance from the Providence Foundation Employee Assistance Fund. I certify that that information is true and accurate to the best of my knowledge.

Employee Signature: _____ Date: _____

Please send application and supporting documentation to providencefoundation@southalabama.edu