**Associate COVID-19 Impact Relief Fund Application-CHRISTUS Ochsner SWLA Foundation**

This program was established for the purpose of providing ***financial assistance to full-time, part-time and PRN Associates of CHRISTUS Ochsner Health Southwestern Louisiana*** who have been impacted by COVID-19. The fund is set up to be used to assist with unpaid time-off because of having the disease, being quarantined due to exposure associated with the disease, having to take unpaid time off due to the disease to care for an immediate family member(s) – spouse, parents, grandparents, children (includes adopted, half and step children), grandchildren, siblings and in-laws (mother, father, brother, sister, daughter and son) or were on short-term disability (60% pay) due to the disease. The funding for this application has been provided through a grant from the Louisiana Workers Compensation Commission and applies to ***full-time, part-time and PRN Associates of CHRISTUS Ochsner Health Southwestern Louisiana*** who have been affected by COVID-19 between February 1, 2020 – April 15, 2021. Completed applications will be reviewed by a committee to determine eligibility for assistance.

***Any CHRISTUS Ochsner Health Southwestern Louisiana*** ***full-time, part-time or PRN Associate*** who meetsthe qualifications listed below is eligible to apply for assistance. The maximum amount an Associate may receive from theAssociate COVID-19 Impact Relief Fund is $500.

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

1. Be employed with ***CHRISTUS Ochsner Health Southwestern Louisiana*** for at least (1) year as PRN, part-time Associate or full-time Associate
2. Have worked for more than 1000 hours within the previous 12 months
3. Have, since February 1, 2020 – March 31, 2021, been off with unpaid time due to COVID-19

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

* Time off during the application period will be confirmed through your Human Resource record that you were out with COVID -19 related situations as defined above.
* Completed applications need to be submitted by emailing to [SWLAassociatecovid19@christushealth.org](mailto:SWLAassociatecovid19@christushealth.org) or through the Foundation’s website <https://christusochsnerswlafoundation.org/associate-covid-19-impact-relief-fund/> that will be linked to the above-mentioned email address. The application can be printed to fill out and then needs to be emailed as well. Deadline for applying is April 9, 2021.

**SECTION 1: INFORMATION ABOUT YOU**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employee Name (print clearly): | | | | |
| Home Address: | | | | |
| City: | | State: | | Zip: |
| Contact phone:  ( ) | | | | |
| Full-time  Part-time  PRN | Dates out with unpaid compensation: | | | |
| Work Location: CHRISTUS Ochsner St. Patrick Hospital CHRISTUS Ochsner Lake Area Hospital | Department: | | | |
| Hire Date: | Job Title: | | Employee ID#: | |

**SECTION 2: DESCRIBE YOUR SITUATION**

Please describe your COVID-19 situation that caused you to be out with unpaid compensation:

How would this financial aid help you and your family?

**SECTION 3: PAYMENT**

**Payment**: If an application is approved, payment up to $500 will be made to the Associate by check from the CHRISTUS Ochsner Southwestern Louisiana Foundation. You will be notified of the status of your application from the contact information you listed on the first page of this application – email (preferred), phone or by mail to the address indicated.

Associate Name, printed clearly:

**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, that the maximum you can request is $500, and that support may be below this amount.

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

Signature: 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, 3 and 4 with all the details requested.

I am enclosing required documentation.

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