CHRISTUS Health Southwestern Louisiana Foundation | Ochsner

Associate Helping Hands Fund Application

The Associate Helping Hands Fund provides financial assistance to CHRISTUS Ochsner Health Southwestern Louisiana Associate, CHRISTUS Health Contract Associate Partner or non-physician Ochsner Associate who is experiencing personal short-term financial hardship due to a tragedy, disaster, or other extreme life event. Completed applications are reviewed by the Associate Helping Hands Fund Committee to determine eligibility for assistance.

Any CHRISTUS Ochsner Health Southwestern Louisiana Associate, CHRISTUS Health Contract Associate Partner or non-physician Ochsner Associate meeting the qualifications listed below is eligible to apply for assistance. Family members of Associates are not eligible for assistance. ***The maximum amount an Associate may receive from the Associate Crisis Care Fund is $1,000 (or an amount determined by the Committee).*** In the event of a catastrophic natural event (hurricane, earthquake, tornado), additional maximum ranges will be considered by the Associate Helping Hands Fund Committee in collaboration with local and regional CHRISTUS Human Resources leadership.

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

1. Been employed as a CHRISTUS Ochsner Health Southwestern Louisiana Associate, CHRISTUS Health Contract Associate Partner or non-physician Ochsner Associate for at least (1) year.
2. Have worked for more than 1000 hours within the previous 12 months.
3. Have not received assistance from the fund within the past 24 months and no one else in the same household has received assistance from the fund within the past 24 months.
4. 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 to the Foundation.**

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:		Zip:
Contact phone: ( )		
Have you applied to this program before? ☐Yes ☐No	If so, when?	
Work Location:	Department:	
Hire Date:	Job Title:	Employee ID#:

Associate Name, printed clearly: _____

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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: _____
(tornado, flood, type of illness or surgery, deceased's name & relationship, name of circumstance, etc.) (must be within 60 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?

Describe what happened that caused your financial hardship:

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:

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Associate Name, printed clearly: _____

SECTION 3: SPECIFIC REQUEST (To be completed only in the event of a large scale natural disaster event (hurricane, tornado, earthquake)

Associate Helping Hands funds are paid to Associates or 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)

The Program **cannot** consider:

- reimbursements to employee or other individual
- legal fees
- credit card debt
- cable, phone or internet, unless required by job
- car payments
- furniture, appliances, electronics
- grave markers
- collection agency payments
- student loans or expenses
- repairs due to negligence or neglect
- travel expenses
- insurance payments or co-pays

Payment: If an application is approved, payment(s) to an Associate or to the vendor(s) will be made by check and will include the employee's account number, if applicable, and a copy of the bill or invoice provided with the application. You will be notified of the status of your application by phone call, email or by mail to the address indicated on the application or via email if you listed an email address on the first page.

Documentation: Please list the bills you need assistance with, ***listing the most important ones first***. If you are requesting payments to more than three vendors, attach a page with identical information provided. Please include the following:

- Bill, invoice, lease, mortgage coupon or statement of amount due.
- A published obituary or death certificate is required for expenses relating to a death that are not included on an invoice from a mortuary.
- Fire, police, or other official reports are required for applications resulting from catastrophic events.

Vendor Name:		
Vendor Mailing Address:		
City:	State:	Zip:
Your account number:	Invoice/Bill due date:	
Payment amount:		

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 in a calendar year (except in extraordinary circumstances), and the amount an Associate may receive from this Fund is based on need, on the eligibility requirements outlined, and on a tiered structure determined and reviewed by the Associate Helping Hands Fund Committee.

Your signature below also certifies that the information you provided is true and complete, releases CHRISTUS Ochsner SWLA 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:_____

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 am enclosing current required documentation for each vendor listed in Section 3. If applicable, I also included documentation of the incident, such as an obituary, police, or fire report.

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

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