**FRIENDSHIP FUND APPLICATION**

*PLEASE READ THIS CAREFULLY*

APPLICATIONS ACCEPTED ONCE IN A 6 MONTH PERIOD

Employees could be eligible for up to $1000 on an annual basis ($2,500 Lifetime Maximum)

**FRIENDSHIP FUND ELIGIBILITY CHECKLIST:**

1. Must be a regular full time, part time or DSS employee for ***6 straight months***
2. Must not have used the Friendship Fund in the past 6 months
3. Must have had a ***recent catastrophic event*** resulting in extreme personal crisis such as:
   * Employee or Spouse on LOA without pay/ without full pay
   * Fire or other natural disaster
   * Spouse laid off or recently deceased
   * Recent loss of child support payments
   * Excessive medical bills
   * Other events that are catastrophic or unexpected in nature
4. Upon an employee submitting an application, a copy of the bill(s) that you would like the committee to consider paying must be attached. ***No bills will be paid out directly to the employee.***
5. Must give a detailed explanation of the recent catastrophic event on the backside of the application

Please submit applications to **\_HR Friendship Fund**

Please call Human Resources at 812-450-2359 with any questions.

\*Upon an employee’s submission of a ***second***Friendship Fund application, whether approved or denied, ***the employee must attend financial counseling through the EAP Financial Assistance program*** first before they will be allowed to submit a third request. There is no cost to the employee for this service. \*

**APPLICATION FOR FRIENDSHIP FUND – Deaconess Health System**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hire Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Job Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full Time/Part Time/DSS: \_\_\_\_\_\_\_\_\_

*(Must be employed for 6 months)*

Daytime Contact Phone Number: Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for the Friendship Fund before? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Qualifying Event** | | |
| **Check Box** | **Reason** | **Effective Dates** |
|  | Fire or other natural disaster |  |
|  | Spouse/Significant Other lost employment |  |
|  | Excessive Medical Bills |  |
|  | Leave of Absence (Spouse or self) |  |
|  | Loss of Child Support Payments |  |
|  | Other: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Monthly Expenses & Income** | | | |
| **Expense** | **$$** | **Income** | **$$** |
| Rent/House payment |  | Spouse’s Income |  |
| Car Insurance |  | Child Support Received |  |
| Car Payment |  | Disability Income |  |
| Utilities |  | Other: |  |
| Groceries |  |  |  |
| Phone |  |  |  |
| Other: |  |  |  |

**Type of Help Needed**

BILL AMOUNT

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the application is approved at the $1000 annual maximum and I need additional help for otherwise eligible expenses (must provide proof of expenses), please pay out the following PTO hours:*

Number of PTO hours to payout: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [may not exceed 80 hours] [Please note that Employee must have at least 40 hours of PTO remaining in bank after payout]

Signature of Applicant Date

**HUMAN RESOURCES DEPARTMENT FINAL APPROVAL (Circle one):**

APPLICATION APPROVED APPLICATION DENIED

COMMENTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature, Human Resources Date