GRACE FUND

Giving Relief and Care for Team Members

The GRACE Fund is a crisis-based emergency financial assistance program for Self Regional Healthcare team members. It is funded by team members' contributions to the Foundation Team Member Campaigns. Please note the following policies and guidelines:

- **The crisis must be a one-time occurrence.**
- **The crisis must be of a devastating, major, serious, life-altering nature.**
- **Applies to team members, spouse and legal dependents up to age 18 or 25, (Full-time college student)**
- **Team members must have exhausted other resources available that will impact the crisis.**

POLICIES AND GUIDELINES:

- Applications must be complete and include all necessary documents which include proof of the emergency and previous two pay stubs.
- Team members must have worked at Self Regional Healthcare for at least six months to qualify for assistance.
- Funds will only be offered if available. **Maximum grant per incident is $1,000**.
- Maximum lifetime of three (3) grants for assistance. Exceptions to this restriction may be granted if the team member donates back to the Grace Fund monies received from prior grants.
- One application per family for a single incident will be accepted.
- All grants require the approval of a majority of the committee.
- A decision will be reached within ten business days.
- Checks issued require up to ten business days and must be picked up during regular business hours unless other arrangements have been made in advance.
- Neither the Committee nor the Foundation will be responsible for late payments.

The emergency must fall into one of the following categories:

Medical

Eligible:

- Medical treatment not covered by insurance

Not Eligible:

- Medical treatment covered by insurance
- Elective Procedures

Loss of Primary Residence

Eligible:

- Dwellings/contents that are not covered or are under-covered by insurance
- Evictions related to catastrophic events

Not Eligible:

- Dwellings/contents that are covered by insurance
- Evictions unrelated to catastrophic event

Family Issues

Eligible:

- Family Issues not covered by insurance
- Sudden loss of income resulting from one or more of the following:
  - Death of spouse or child
  - Ineligible for unemployment or severance
  - Layoff
  - Divorce or becoming a single parent

Not Eligible:

- Recurring bills (utilities, insurance, gas, food, etc.)
- Child support/alimony
- Family issues covered by insurance

SELF REGIONAL
HEALTHCARE FOUNDATION

Confidential
GRACE Fund Application

Date: _____

Employee ID Number: _____ Date of Employment_____

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Telephone Numbers: (Home) _____ Work:_____

Department or Area of Employment:_____

Immediate Supervisors Name: _____Work Number:_____

Number of people in the household: Adults- _____ Children - _____

Assistance Requested (be specific and include a copy of each bill you are requesting to be paid):

_____

_____

_____

The GRACE Fund is help for team members who find themselves in an extraordinary crisis situation.

Please explain in detail the nature of your crisis situation which has resulted in this request:

(please use another piece of paper if needed).

Which category does your crisis fall under? Medical___ Loss of Primary Residence__ Family Issues___

_____

_____

_____

_____

Dollar amount of assistance requested: _____

Have you received help from the Grace Fund before?_____

If so, how much and when? _____

What community services have you explored for help and what assistance have they offered?

(Salvation Army, United Ministries, Red Cross, GLEAMS, United Way, Food Bank, Church, etc)

_____

_____

_____

GRACE Fund Application

(Continued)

Please provide all weekly / monthly income and expenses for **ALL** members of your household:

Income (monthly)	Dollar Amount
Yours	
Spouse (or significant other)	
Child Support	
Other Income (specify)	
Savings	
Flexible Spending Account (FSA)	

Expense (monthly)	Dollar Amount
House Payment or Rent	
Utilities	
Home Phone	
Cell Phone	
Cable/Satellite/Internet	
Automobile	
Food	
Gas	
Child Care	
Other (specify)	

I understand that my Supervisor or Department Head may be contacted regarding this application. I attest that information I have provided is correct and further understand that any false statements will forfeit any consideration from the GRACE Fund. By signing below, I give you permission to verify all information on this application.

_____

Applicant's Signature

(Please return completed applications to the Foundation office).