Team Member Assistance Fund Application

Submit a completed application with the required documentation to TeamMemberAssistanceFund@fmolhs.org or turn into your local Pastoral Care office. A representative from HOPE Ministries will contact you to complete the financial assessment. The TMAF Committee will review a summary of the assessment and render a decision. Within 48 hours, a representative from HOPE Ministries will follow up with the team member to discuss the final decision regarding the application.

REQUIRED DOCUMENTATION FOR FINANCIAL ASSISTANCE

IDENTIFICATION:

- Employee Name Tag, Valid Driver's License or Valid Picture ID.
- Name and Date of Birth for every member of the employee's household.

PROOF OF INCOME:

- For EVERY member of household (This may be one or more of the following sources).
  - Last 2 pay check stubs (if spouse works, spouse's last 2 pay checks)
  - Social security statement
  - Social security disability statement
  - Social security supplemental income statement
  - Child support income
  - Food stamp statement
  - Childcare assistance statement

PROOF OF EXPENSES:

- Rent/Lease Contract; Mortgage Statement, Eviction Notice *** Must Show This***
- Must show up to date proof of the following (if applies to employees):
  - Electric; disconnect bill
  - Water and sewage; disconnect bill
  - Natural Gas
  - Telephone land and/or cell phone bill
  - Car Payment
  - Car insurance
  - Child care
  - Medical bills
  - Any other bill paid on a regular monthly basis (storage, rental, furniture rental, credit cards and loans)
  - A bill that has put the employee into financial difficulty

FOR ANY ASSISTANCE RELATED TO VEHICLES the employee must present the following:

- Valid driver's license
- Proof of ownership of vehicle
- Proof of insurance on the vehicle

Please email the documents requested and the completed application packet below to teammemberassistancefund@fmolhs.org.

FMOLHS Team Member Assistance Fund Confidentiality Form:

The below signature represents my understanding and agreement that any funds received through FMOLHS Team Member Assistance Fund will be kept in strict confidence.

I will not:

Discuss the amount I received through the Team Member Assistance Fund (if any) with any other people, especially other team members, family or friends.

I will:

A. Give accurate and honest information as it relates to accessing funds through the FMOLHS Team Member Assistance Fund.
B. Make every effort to be fair in my dealings with the committee as they attempt to review my case.

_____ _____

Signature of applicant Printed name of applicant

_____ _____

Date Committee Representative

Orginal:1/12

Franciscan Missionaries of Our Lady Health System
Team Member Financial Assistance Application

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Employee Number: _____ **Date of Hire:** _____

Department: _____ **Job Title:** _____

Home Address: _____ **Apt. #** _____

City: _____ **Parish:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ **Other Phone #:** _____

(After phone # indicate whose # it is and relationship to team member)

Members of the Team Member's Household:

Last Name	First Name	SS#	DOB	Age	Relationship to team member: (Husband, wife, son, daughter, niece, nephew…)

Total Number of Members in the Household: _____ (list additional members on page 2)

REQUEST FOR ASSISTANCE

Type of Assistance Need:

_____

_____

If financial assistance is approved, amount needed: _____

For Office Use: Decision: _____

VERIFICATION OF INFORMATION/PRIVACY RELEASE

I certify that the information I have provided is true and correct. I give my consent for FMOLHS and/or HOPE Ministries to verify my information as well as to release my information for this application to other social service or faith-based agencies and funding sources as needed for the purpose of providing services or to generate statistics on assistance needs.

Team Member's Signature: _____ Date: _____

Interviewers' Signature: _____ Date: _____

Name_____

HOUSEHOLD MONTHLY INCOME

HOUSEHOLD MONTHLY EXPENSES

Sources:	Net Amount	Bill	Amount (list a one month amount only)
Team Member's Pay Check 1		Rent/Mortgage	
Team Member's Pay Check 2		Electric	
Spouse's or Other Pay Checks		Natural Gas	
Food Stamps		Water & Sewage	
Social Security		Telephone (landline & cell)	
Child Care Assistance		Cable and/or internet	
Child Support		Food	
Other:		Household Goods	
		Child Care	
		Gasoline for Car	
		Car Payment	
		Car Insurance Payment	
		City Bus Transportation	
		Others: Please list all other monthly bills, for example, medicine, medical, loans, etc.	
TOTAL INCOME		TOTAL EXPENSES	

Please attach to this application form the appropriate documentation. Make copies of the documentation. Never keep the team member's original document.

ADDITIONAL NOTES (Additional household members, continued reason for request, etc.)

_____

_____

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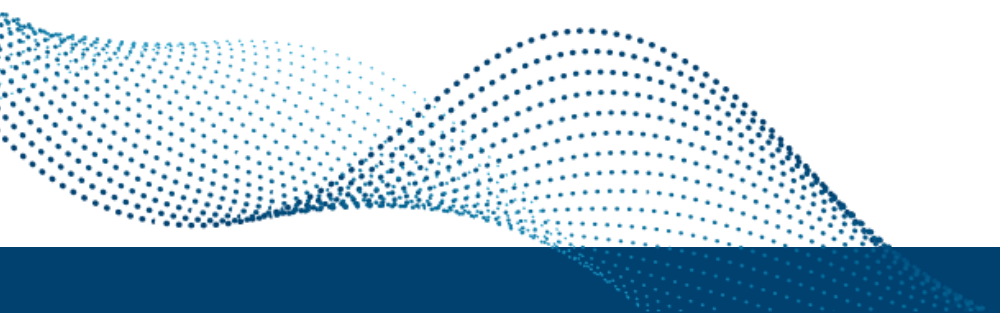

Franciscan Missionaries of Our Lady
HEALTH SYSTEM