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| **APPLICATION FOR ASSISTANCE** |

**THE PROGRAM**: The Employee Assistance Fund helps employees or eligible dependents who are experiencing economic hardship due to certain emergency situations to include, but not limited to; life threatening illness or injury, natural disaster, death of a member or immediate family member, unexpected medical expenses which exceed insurance provisions resulting in hardship, or an uninsured loss due to fire which resulted in hardship.

**ELIGIBITLITY:** The Employee Assistance Fund is available to any current or former employee, volunteer, immediate family of employee, a member who was killed or disabled in the line of duty immediate family or other fulltime law enforcement personnel, while employed within Charlotte County, Florida or a neighboring county, or for his/her spouse or dependent child. Please see Article V Section 1 for more information.

**FUNDS:** The maximum amount available for assistance is $5,000 for each event or as described in the bylaws. Applicants can only requests assistance twice in a calendar year. All payments are made directly to vendors as bill payments; no assistance funds will be sent directly to applicants.

The Employee Assistance Committee Members are available to assist all applicants in this process. Please email EAF@ccso.org or visit ccsoeaf.org for a list of current members to speak with.

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| **SECTION A: WILL YOU QUALIFY?** |

**To qualify for assistance you must meet the following criteria:**

1. The applicant must meet the employment requirements outlined above and in Article V Section 1 of the bylaws.
2. The applicant must be experiencing financial hardship that affect your ability to pay for basic living needs.
3. The applicant does not have sufficient financial resources to meet the need, including life insurance and has reasonably exhausted all other avenues of obtaining financial assistance.
4. The situation MUST fall into one of these five categories:

**Life-Threatening or Serious Illness or Injury:** For the employee, spouse and eligible dependent(s). The assistance is not a substitute for medical insurance and employees do not automatically qualify for assistance when they, or their dependents, are diagnosed with or suffer a life-threatening or serious illness or injury. There must be a resulting financial need including an inability to pay basic living expenses. *Doctor confirmation, medical documentation and/or bank statements may be required*

**Natural Disaster:** For situations, such as wildfire, flood, tornado, hurricane, severe storms or earthquake, that have damaged or destroyed the employee’s primary residence. The assistance cannot pay to repair other property and cannot pay to replace non-essential items, such as electronics or furnishings. *Photographs or insurance reports may be required.*

**Death Incident:** This includes the death of the employee, spouse or eligible dependent(s). The loss of income or the cost of funeral expenses or medical bills must prevent an employee or the employee’s family from affording basic living expenses. The Fund can assist with travel to/from immediate family funeral and other funeral expenses.

**Educational Assistance:** Shall be utilized to provide scholarship assistance to the spouse and /or dependent children of a qualified applicant. Eligibility shall be determined on an individual basis by the EAF Committee. Assistance for a four-year undergraduate studies shall not exceed $1,000 annually and $500 annually for a two year state college. Please see Article VI for more information.

**Catastrophic or Extreme Circumstances:** This includes but is not limited to fire, major home damage that could not be prevented, serious crime against the employee (robbery, arson, assault, domestic abuse, or another reportable crime) that impacts the ability to afford basic needs. **Catastrophic or extreme circumstances do not include:** credit card bills, home foreclosure, car repair or accumulated financial distress.

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| **SECTION B: APPLICANTS GENERAL INFORMATION** |

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| Applicant Name: |       |
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| Address: |       |
|  |  |
| City: |       | State: |         | Zip Code |       |
|  |  |  |  |  |  |
| Phone Number: |       | Secondary Phone Number |       |

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| **SECTION C: DESCRIBE YOUR SITUATION** |

Which qualifying situation caused the financial hardship?

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| Life-Threatening or Serious Illness or Serious Injury | [ ]  | Natural Disaster | [ ]  | Death Incident | [ ]  |
|  |  |  |  |  |  |
| Educational Assistance | [ ]  | Catastrophic or Extreme Circumstances: | [ ]  | Other | [ ]  |

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| Have you received assistance from us in the past? | Yes [ ]  | No [ ]  |  |  |
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| Who has been affected by the situation? |       |
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| How many people live in your household? |       | Adults |       | Children | 0 |
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| Describe what has happened to cause your financial hardship:      |

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| Describe in detail your immediate basic needs and amount requested for assistance:  |

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| How will this assistance help you recover from the immediate financial crisis?      |

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| Please tell us anything else that would help in understanding the circumstances of the hardship you or your family is experiencing.       |

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| **SECTION D: ASSISTNACE FUNDS** |

**Funds are only to help pay for limited types of essential living expenses, which include but not limited to:**

* Rent, mortgage or other housing payments
* Temporary housing and security deposits for new housing
* Essential utility bills (electricity, water, etc.)
* Medical expenses (bills), not eligible for reimbursement of covered by insurance.
* Minor home repairs needed to maintain home safety.

**Funds cannot be made to pay for other expenses such as, but not limited to:**

* Legal fees
* Non-essential utilities (cable, phone, etc.)
* Furniture, appliances, electronics
* Accumulated financial issues or credit card debt

If the assistance is approved, The Employee Assistance Fund will make the funds in the form of check(s) payable to the vendor(s) and the applicate will be notified of the payments. **All funds are made directly to vendors as bill payments; assistance funds are not sent directly to applicants.**

Provide the name of the vendor, the complete address, account number (if applicable), amount due, and due date.

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| Vendor Name |       |
| Vendor Address |       |
| Basic Need Covered |       |
| Payment & Due Date |       |
| Account Number |       |

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| --- | --- |
| Vendor Name |       |
| Vendor Address |       |
| Basic Need Covered |       |
| Payment & Due Date |       |
| Account Number |       |

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| --- | --- |
| Vendor Name |       |
| Vendor Address |       |
| Basic Need Covered |       |
| Payment & Due Date |       |
| Account Number |       |

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| **SECTION E: DECLARATIONS AND AGREEMENT** |

No employee is entitled to receive funds, either by their employment, their history of contributions to the fund or because of any precedent inferred from a previous assistance from the fund. Funds will not be made before an applicant has demonstrated an immediate financial need and provided all required documentation.

The application will be treated in a confidential manner by the Employee Committee Fund; however, non-identifying statistical information may be reported on a periodic basis.

Your signature below certifies that the information provided is true and complete, authorizes the Employee Assistance Fund to obtain and/or verify all information necessary to process this application.

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| Applicant’s Signature: |  | Date: |  |