Employee Hardship Program

This Employee Hardship Program is an employee-funded program designed to assist employees with basic living necessities as a result of a natural or civil disaster or an individual’s need for financial assistance as a result of an eligible emergency hardship where no other funds are available.

The Employee Hardship Committee consists of a diverse group of non-management employees from different departments.

Criteria for Eligibility

You must meet the below criteria with supporting documentation to be considered for disbursement of funds for expenses such as rent or mortgage, gas and/or electric, sewer and water, primary home telephone, car or house insurance, and medical bills which are not part of the EMORY HEALTHCARE system. The Employee Hardship Committee will consider applications for the following hardships (provided funds are available).

- death in the family
- unusual medical expenses caused by severe illness or accident
- uninsured losses caused by fire, crime, flood or other disasters
- unusual uninsured expense for the care of a sick family member

To apply for hardship funds, the employee must meet the following eligibility rules:

- be a regular, full-time employee or regular part-time employee in good standing who is scheduled to work 20 or more hours per week for EMORY HEALTHCARE
- be an employee who has not been suspended or received a final written warning in the last 12 months from date of application
- be an employee who has completed 90 days of employment
- has a financial hardship that involves the EMORY HEALTHCARE employee or a member of the employee’s family as defined in the “Employee Emergency Hardship Program” policy

If you need assistance with an EMORY HEALTHCARE bill, EMORY HEALTHCARE Patient Financial Services will work with you on a payment plan through payroll deduction. Employees can make arrangements to pay their hospital or clinic bills by contacting one of the following Patient Financial Services offices:

- Emory University Hospital Midtown Campus, 404-686-2422
- Emory University Hospital Main Campus, 404-686-7030 or 404-686-7041
- The Emory Clinic, 404-778-9815

You are encouraged to consider assistance from other agencies or other potential sources of support such as family members, your place of worship, other local organizations, etc. In certain situations, you may seek additional information or assistance from Emory University’s Faculty Staff Assistance Program at 404-727-4328.
Program Definitions:

Catastrophic Event - is defined as extreme misfortune of the employee or a family member (as defined below) of the employee for reasons beyond their control, related to the employee’s inability to meet basic living necessities as a result of a natural or civil disaster, or the employee’s need for financial assistance as a result of an emergency hardship caused by

(1) death in the family;
(2) unusual uninsured medical expenses caused by severe illness or accident;
(3) uninsured losses caused by fire, crime, flood or other disasters;
(4) unusual uninsured expense for the care of a sick family member.

Family Member - is defined as a Child, Dependent, Spouse, or Parent.

Child - is defined as a biological or adopted child, foster child, step-child, legal ward or child for whom a person has legal custody.

Dependent - is defined as an individual meeting the criteria used by the Internal Revenue Service in defining “dependent” will be considered a dependent for purposes of this policy.

Spouse - is defined as a husband or wife as defined by Georgia State law.

Amount of assistance is related to the extent of the need, however the maximum award is $2,000 and an employee can only receive funding for a maximum of one event per year (based on the required supporting documentation).

Assistance is provided based on program criteria (see page 1), there is no appeals process if you do not qualify for the program.

To apply for assistance, the application must be completed thoroughly. Failure to answer questions in the application or not submit the required supporting documentation will delay processing of the application for approval.
EHC Employee Hardship Program
Monetary Request & Comprehensive Leave (PTO) Donation Request

Please review the following checklist before submitting your Employee Hardship Program application for Monetary or Comprehensive Leave (PTO) donation requests. Applications must include the following in order to be processed for approval:

(1) Donor forms that indicate unpaid time.
(2) Confirmation statement that indicates review of the comprehensive leave donation policy has occurred prior to submitting the application and donor forms.
(3) Acknowledgement statement that both application and donor forms have been completed and submitted for processing. Application for assistance will not be accepted without donor forms.

Applications submitted without the required supporting documentation or evidential proof will not be accepted for processing and will be returned to the requestor as incomplete.

Provide the following items as proof of the hardship.

- Statement or letter of explanation – A written statement from the requestor that thoroughly explains the reason for the application, including circumstances causing the event and any supporting documentation as proof that the need exists.

- Supporting documentation required at time application is submitted – Application must have one of the applicable forms of documentation (see page 4) in order for the application to be considered complete and accepted for processing. Applications will not be accepted if it does not contain the supporting document as proof for the need.

  - Applicant must provide out of pocket expenses such as late mortgage/rental notice or past due utility statement which has placed them in a financial hardship.
<table>
<thead>
<tr>
<th>Emergency Category</th>
<th>Examples of Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>- Copy of certified death certificate&lt;br&gt; - Newspaper clipping of obituary&lt;br&gt; - Statement from funeral service provider, e.g. estimated invoice&lt;br&gt; - Expense receipts for travel to and from the services for the deceased</td>
</tr>
<tr>
<td>Unusual/Uninsured Medical Expenses (Own severe illness or the care of a sick family member)</td>
<td>- Explanation of benefits (EOB) from insurance company or medical provider; shows “Patient Responsibility” and dates of coverage&lt;br&gt; - Statement or invoice from medical provider that shows “Patient Responsibility” and dates of coverage&lt;br&gt; - Statement from collection agency indicating “patient responsibility” and name of provider and dates of coverage (* Statements from EMORY HEALTHCARE facilities will NOT be eligible for consideration under Employee Hardship Program. Employees should be referred to Patient Financial Services to set up payment arrangements.</td>
</tr>
<tr>
<td>Uninsured Losses – Fire Related</td>
<td>- Police report&lt;br&gt; - Fire department report&lt;br&gt; - Proof of residence (utility bill with address, drivers’ license or address on pay advice are acceptable forms of proof)&lt;br&gt; - Proof of homeowner’s insurance denial&lt;br&gt; - Estimate of repairs from contractor, including name of contractor, items to repair and cost to repair</td>
</tr>
<tr>
<td>Uninsured Losses – Flood Damage</td>
<td>- Proof of homeowner’s insurance denial&lt;br&gt; - Proof of residence (utility bill with address, drivers’ license or address on pay advice are acceptable forms of proof)&lt;br&gt; - Estimate of repairs from contractor, including name of contractor, items to repair and cost to repair</td>
</tr>
<tr>
<td>Crime (ex. theft and burglary)</td>
<td>- Police report&lt;br&gt; - Fire department report&lt;br&gt; - Proof of residence (utility bill with address, drivers’ license or address on pay advice are acceptable forms of proof)&lt;br&gt; - Proof of homeowner’s insurance denial&lt;br&gt; - Estimate of repairs from contractor, including name of contractor, items to repair and cost to repair</td>
</tr>
</tbody>
</table>
Employee Hardship Program  
Application

Please complete all portions of the application. If something does not apply please put N/A. If you have questions about the application, please contact the Employee Hardship Program Coordinator in the Benefits department.

Please bring or fax (404.686.4750) your completed application to Human Resources at Emory University Hospital, D219, or the W.W. Orr Building, Fifth Floor, on the Midtown Campus to the attention of “Employee Hardship Program.” Incomplete or illegible applications will be returned for resubmission. The committee will review the completed application and respond as quickly as possible. Your name, family member’s names, employee ID number, department and job title are not shared with the Employee Hardship Program - only the Employee Hardship Program Coordinator has this demographic information. Application information will be kept confidential.

The information asked on the application is necessary in order to ensure fair and equitable administration of the program and distribution of the funds. Completion and submission of this application does not guarantee approval.

Select One:
This is a request for: ☐ Comprehensive Leave/PTO (complete sections A,B, D & E) 
Comprehensive Leave PTO Qualifications: Applicant must lose one half of regularly scheduled paycheck while in an unpaid leave of absence job status. Ex. 80hrs scheduled but only works 40hrs during pay period.

☐ Monetary (complete A – D)

Section A

Employee Name ________________________ Employee ID _________ Home/Cell Phone _____________
Department Name _______________________ Work Phone _____________ Job Title________________
Supervisor’s Name _______________________ Supervisor’s Telephone _______________________ 
FT or PT _____ Hours Worked/Week ________ Hire Date _________ Gross Annual Pay _____________
Marital Status _____ Spouse Name _________________________ Home/Cell Telephone _____________
Spouse’s Employer _______________________ Job Title ______________ Work Phone ______________
FT or PT _____ Hours Worked/Week ________ Hire Date _________ Gross Annual Pay _____________

Have you previously received funds from the Employee Hardship Program  ☐ Yes  ☐ No
If so, when______ Amount Received $__________ ☐ Comprehensive/PTO  ☐ Monetary ☐ Both
Employee Hardship Explanation

Section B

Please describe in detail the reason you are requesting assistance. It is necessary that the committee know all the facts related to the events surrounding the employee’s hardship. (Use separate sheet if necessary)  

(Please write legibly)

What assistance do you need?

All questions must be complete to be considered for funds. Please attach any supporting documents you may have. If you have no information, please write not applicable (N/A) in the areas below.

- Death in the family (ex. Certified Death Certificate, Obituary, Funeral Service invoice, requestor’s receipts of associated expenses)
- Unusual medical expenses caused by severe illness or accident (ex. Medical Bill(s), Certification of Medical condition)
- Uninsured losses caused by fire, crime, flood or other disasters (ex. Insurance Claims, Police Report)
- Unusual uninsured expense for the care of a sick family member (ex. Expense Receipts)

Section C

FINANCIAL REQUEST

Please prioritize, in order, the items that should be paid upon approval by the Committee of your application:

<table>
<thead>
<tr>
<th>Name of Vendor or Provider</th>
<th>Purpose of Funds</th>
<th>Amount Due</th>
<th>Amount Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td>3</td>
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<tr>
<td>5</td>
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<td>$</td>
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*Applicant must attach the current invoice(s), bill(s), and other required documents.
Authorization

Section D

I, the applicant, give permission to release the information I have provided to the Employee Hardship Committee members.

I understand that application to the program does not guarantee that assistance will be provided. I also understand in order to receive assistance I must meet the following conditions:

- be a regular, full-time employee or regular part-time employee in good standing who is scheduled to work 20 or more hours per week for EMORY HEALTHCARE
- be an employee who has not been suspended or received a final written warning in the last 12 months from date of application
- be an employee who has completed 90 days of employment
- has a financial hardship that involves the EMORY HEALTHCARE employee or a member of the employee’s family as defined in the “Employee Emergency Hardship Program” policy

I understand that assistance will be given in the form of comprehensive leave/PTO or a check.

I understand if I falsify or submit fraudulent information I will be required to repay the amount of money awarded, and it will be grounds for termination. Employee Initials: _____ Date_____

I understand a decision of whether funds will be granted will be made as quickly as possible after receipt of the completed application and required supporting documentation (excluding Saturday, Sunday and holidays). EMORY HEALTHCARE reserves the right to change or eliminate this program at any time. There is no appeals process and any change or modification is subject to administrative approval.

Employee Signature: ____________________________ Date: ____________________________

Approval Section (For HR purposes only)

<table>
<thead>
<tr>
<th>Application received by _____________</th>
<th>Date Received By HR Hardship Coordinator _____________</th>
<th>Application Process By AP Date: _____________</th>
</tr>
</thead>
</table>

Committee: □ Approved □ Denied Date ____________________________
Employee Hardship Program  
Comprehensive Leave/PTO Donor and Recipient Application

Section E
PLEASE PRINT INFORMATION
DONOR INFORMATION

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Employee ID Number</th>
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<table>
<thead>
<tr>
<th>Street Address:</th>
<th>Home Phone:</th>
<th>Work Phone:</th>
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<table>
<thead>
<tr>
<th>City, State, Zip Code</th>
<th>Department:</th>
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DONATION INFORMATION

I wish to donate:  □ Comprehensive Leave (PTO)

I wish to donate my comprehensive leave/PTO to:  □ Recipient (as detailed below)  □ General Leave Bank

Note: Additional hours not received by the recipient are automatically moved to the general leave bank.

I wish to donate __________ hours from my PTO leave bank  (must be a minimum of 8 hours)
You must maintain at least an 80-hour balance after donation.

RECIPIENT INFORMATION  (Comprehensive Leave/PTO Only)

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Employee ID Number</th>
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<table>
<thead>
<tr>
<th>Department:</th>
<th>Telephone Number:</th>
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I have read and understand the provisions of the EHC Comprehensive Leave/PTO Donation Policy before signing this document.  I understand that completion of this form is not a guarantee of approval.

Donor’s Signature: ___________________________  Date: ________________

Dept. Director’s Approval: _____________________  Date: ________________

Please send the completed form to:
EHC Employee Resource Center/Benefits
Fax number: 404-686-4750
Email to: EHC.HR/Benefits@emoryhealthcare.org

Note: If you are donating to a co-worker, please confirm with the potential recipient that they have completed and submitted the hardship application to the Employee Resource Center to be reviewed for eligibility purposes.