Application for Assistance

The Tenet Care Fund was established to provide support to Tenet employees, during ***catastrophic emergency situations***. **It is only through the generous donations of fellow Tenet employees that the Care Fund is possible.** The Care Fund Board of Directors and Care Committee serve as stewards for these funds to ensure that the grants awarded meet the criteria and guidelines of the Tenet Care Fund. Assistance for emergencies and crisis situations are considered on a case-by-case basis, and requested funding is not guaranteed.

Do I Qualify for Care Fund Assistance?

Note: The Care Fund does not provide assistance for non-emergency situations or general financial hardship.

YES

I'm seeking help due to:

- **A disaster**, i.e., fire, flood, tornado, hurricane, or earthquake, OR
- **Critical illness**, serious injury, or death affecting you and your immediate family, OR
- **Other** qualifying emergency event or crisis situation (to be considered on a case-by-case basis)

Event must have occurred within the **last 90 days**

NO

I'm seeking help due to:

- General financial hardships that are not created by a disaster or an unexpected tragedy
- Financial hardships that result from routine expenses (car repairs, home maintenance)
- Costs related to divorce or separation, including costs related to child support or non-receipt of child support
- Wages lost from hours being cut
- Wages lost due to inclement weather
- Job loss of a family member
- Struggle with paying medical deductible as a result of choosing a high-deductible health plan, or any other insurance deductibles
- Lack of disability insurance
- Bankruptcy

The Application Process:

1. Please complete **Sections A and B** and gather all required supporting documentation.
2. Once completed, submit your application to your ***local HR department***.
3. Your local HR department will complete Section C of the application and submit it to the Care Fund on your behalf.
4. Your application will be reviewed by the Care Fund Committee to determine if it is qualified for funding.
5. Your HR representative will be contacted regarding the committee's decision.
6. For updates on the status of your application, ***please contact your HR department.***

Please Let Us Know About:

OTHER AVENUES OF SUPPORT Employees experiencing hardship are encouraged to consider other avenues of support such as **cashing in PTO**, **401(k) loans or hardship withdrawals**, **Employee Assistance Program (EAP), as well as any government and/or local community programs.** *Please list all other efforts you have put forth to alleviate your financial hardship.* ***Please keep in mind, The Care Fund is meant as a last resort and is not a guaranteed source of funding.***

_____
_____
_____
_____
_____
_____

PREVIOUS ASSISTANCE ***Have you previously applied for*** and/or received financial assistance from the Tenet Care Fund or any other similar program administered by Tenet or your facility/hospital? **Please note, only one grant will be awarded in a 12 month period.**

Yes ☐ No ☐	If yes, date:	Name of program:	Amount received: $

Section A: APPLICANT GENERAL INFORMATION

Please note: Your name, social security number, address, phone number, etc. will NOT be revealed to the Care Fund Committee. The committee will receive your information with a random case number, **which will not include the information on this page.**

Hospital/Location Name:	City:	State:
Employee Name:	Last four digits of employee social security number:	
Employee Home Address (No P.O. Box):	City:	State:	Zip Code:
Employee Work E-mail Address:		
Employee Home Phone:	Employee Cell Phone:	

If your application is approved, funds will be sent via **Direct Deposit** to the bank account on file for your paycheck. If you do not currently receive your paycheck via Direct Deposit, please provide the address where a check should be sent. *NOTE: Detroit Medical Center and USPI employees must complete the attached request form to receive funds via direct deposit.*

Send check to: (if address is different from above)

Street City State Zip

Legal Dependent Information ***(Please see definition of eligible dependents in the Application Information and Instructions section of the Care Fund website at www.tenetcarefund.org)***		
Dependent Name:	Age:	Relationship to Employee:
Dependent Name:	Age:	Relationship to Employee:
Dependent Name:	Age:	Relationship to Employee:
Dependent Name:	Age:	Relationship to Employee:
Other than legal dependents, do any other individuals depend on you for financial support?	Yes ☐	No ☐
If yes, please briefly describe:		

Section A: APPLICANT GENERAL INFORMATION, CONT.

ANNUAL Household Income

Employee's Annual Salary: $	Total Annual Household Income: $

MONTHLY Household Income

Applicant's NET (take-home) pay, excluding overtime	$	per month
Spouse's / partner's take-home pay	$	per month
Other household income (from adult children, roommate, etc.)	$	per month
Self-employment / second job take-home pay	$	per month
Rental income	$	per month
Retirement / pension / 401(k)	$	per month
Social Security / SSI	$	per month
Worker's Compensation / disability	$	per month
Other	$	per month
Total Monthly Income	**$**	**per month**

MONTHLY Expenses

Rent / mortgage	$	per month
Electricity	$	per month
Gas	$	per month
Home phone / cell phone	$	per month
Water	$	per month
Food	$	per month
Car payment(s)	$	per month
Car insurance	$	per month
Child care / school tuition	$	per month
Medical costs not covered by insurance	$	per month
Loans / credit card payments	$	per month
Cable / satellite TV	$	per month
Tuition, books, fees	$	per month
Other	$	per month
Total Monthly Expenses	**$**	**per month**

Liquid Assets/PTO Balance

Total savings/liquid assets	$
PTO balance	hours

Additional financial information may be requested for verification of expenses and financial hardship.

Section B: NATURE OF APPLICATION (CHOOSE ONE)

☐ **"MEDICAL" (extended illness/injury) assistance**

The Care Fund can help employees who have an extended illness or an injury to themselves or within their immediate family, which requires absence from work and/or excessive medical costs resulting in a critical economic hardship. ***The Care Fund does not reimburse for medical bills or premiums but does help pay for essential living expenses such as rent/mortgage, utilities, and food when a medical condition has resulted in a loss of income***. All sources of income, including Worker's Compensation and/or Disability payments will be considered during the review process.

Required Documentation

- Physician documentation that identifies the type of illness or injury and the length of time the individual is unable to work.
- Copies of overdue living expenses that are a direct result of this event
- Photos may be requested in certain situations

☐ **"NATURAL DISASTER" assistance**

The Care Fund can help employees who are unable to pay for housing, food, clothing and other basic living essentials because a natural disaster such as fire, flood, tornado, hurricane, or earthquake has damaged or destroyed their primary residence. Levels of financial assistance are based on household size, extent of damage and past levels of emergency assistance by relief organizations.

Required Documentation

- Fire, incident or insurance reports
- Repair estimates or any other documents that support the application should be submitted when available
- Please include proof of insurance
- Photos may be requested in certain situations

☐ **"OTHER" Assistance**

Mark this section **only** if you have experienced a critical emergency hardship ***other than*** a disaster or extended illness/injury, as defined in the sections above.

The Care Fund can help applicants who are unable to afford housing, utilities, food, clothing, and other basic living expenses because of catastrophic or extreme circumstances beyond the applicant's control. These may include violent domestic abuse or other situations the applicant could not avoid or prevent. Funeral expenses related to the death of immediate family members (mother, father, children, spouse) will be considered if long-distance travel is required and/or it creates a financial hardship. Grants for travel expenses related to attending the funeral of an immediate family member will be for the employee only and limited to a maximum of $500. Applications involving theft are not generally funded but will be reviewed on a case-by-case basis.

Assistance received from community organizations and/or insurance will be considered when reviewing this type of request and determining a grant amount.

Required Documentation (as they apply to your situation)

- Copies of active restraining order
- Copies of police reports
- Copies of insurance reports
- Copies of deceased information

Section B: NATURE OF APPLICATION, CONT.

Date event or situation occurred:

Please provide a brief description of the situation and include any information that will help in assessing this application. (Please omit identifiable information such as names, hospital locations, cities, etc.)

Which basic immediate living expenses do you need assistance with?

☐ Housing	☐ Electricity / Heat	☐ Water	☐ Food	☐ Clothing	☐ Other

Please provide details of need:

Next Step:

Now that sections A and B are complete, please forward the application to your local HR department for additional processing and submission to the Tenet Care Fund.

Section C: Human Resources Declaration

This section must be completed and signed by your local HR REPRESENTATIVE.

HR Representative: Please complete all of the information requested below and confirm this application meets the eligibility and guidelines for Care Fund Assistance. The guidelines can be found on page 1 of this application. Please help your employee explore all additional avenues for assistance including PTO, EAP, 401(k) loan or hardship withdrawal, and/or government and community programs.

NOTE: ***If this page is incomplete, the application will be returned and will result in a processing delay.***

APPLICANT INFORMATION			
Full Name:			
Employment Status:	Full Time ☐	Part Time 1 ☐	Part Time 2 (PRN) ☐ *Must have worked a minimum of 12 hours (one full shift) in the month prior to the date that the incident occurred.*
Employee Position/Title:			Length of Employment with Tenet: years ☐ months ☐
Annual salary: $	Average paycheck amount per 2-week period: $		Most recent 2-week paycheck amount: $
Has any income been lost due to this hardship? ☐Yes ☐No			**If yes, how much?** $
Is the applicant currently out on a leave of absence? ☐Yes ☐No	If yes, what was the starting date? What is the anticipated end date?		
How many PTO hours does the applicant have available to use?			XILL hours?
Does the applicant contribute to the 401(k) plan? ☐Yes ☐No	If yes, has the applicant applied for a 401(k) loan? ☐Yes ☐No		If yes, has the 401(k) loan been granted? ☐Yes ☐No
Does the applicant have medical insurance? ☐Yes ☐No	If applicable, does the applicant have renters or homeowners insurance? ☐Yes ☐No		
Does applicant have disability insurance? ☐Yes ☐No	If yes, has a disability claim been filed? ☐Yes ☐No		If yes, what is the benefit amount? $
Is applicant currently receiving Worker's Compensation benefits? ☐Yes ☐No ***If yes, please refer to the Medical qualification box on page 5***			

Is this Care Fund grant request the result of an unexpected emergency or crisis?	☐Yes	☐No
Did the event occur in the last 90 days?	☐Yes	☐No
Has a critical emergency need been demonstrated?	☐Yes	☐No
Was the event caused by a non-emergency situation or general financial hardship issue?	☐Yes	☐No
Please provide any addition information that you feel is relevant and important in understanding the applicant's situation and supporting the financial need and hardship resulting from the situation.		

HR Representative ONLY: Please send the signed application (in its entirety) and available documentation to the Tenet Care Fund at CareFund@tenethealth.com

APPLICANT DECLARATION AND AGREEMENT

Employee Signature and Attestation

I understand that no employee is entitled to receive a grant, either by their employment, their history of contributions to The Care Fund or because of any precedent inferred from a previous grant from The Care Fund. Grants will not be made before an employee has demonstrated a critical catastrophic immediate need.

I understand further that this application will be treated in a confidential manner by The Care Fund; however, non-identifying statistical information will be reported to Tenet on a periodic basis.

Employees are expected to provide truthful and accurate information. In its due diligence, if The Care Fund discovers any information in this application to be materially untrue or fraudulent, I recognize that I may no longer expect this application to be treated confidentially and also recognize that information provided herein may be reported to Tenet.

My signature below certifies that the information provided is true and complete, authorizes The Care Fund to obtain and/or verify all information necessary to process this application, and releases Tenet and The Care Fund from any liability associated with the rejection of or funding of this application. In addition, I hereby agree to provide any requested documentation supporting the information provided.

Employee Applicant Signature:
Date:

HR Representative: Please review entire application with the employee prior to submitting.

HR Declaration
To the best of my knowledge, this employee has experienced a disaster or emergency hardship and sustained damages or losses that necessitate financial assistance. **In addition, I verify that she/he is employed by Tenet and the annual salary information is correct.**
HR Director or HR Representative's Name:
HR Director or HR Representative Signature:
Phone Number:

HR Representative ONLY: Please send the signed application (in its entirety) and available documentation to the Tenet Care Fund at CareFund@tenethealth.com

Electronic Funds Transfer Authorization
Care Fund Grant

If your application for assistance is approved by the Care Committee, the grant will be directly deposited into your designated bank account. To expedite payment, please complete the following authorization and return the signed form to CareFund@tenethealth.com for processing.

Hospital/Location Name:	City:		State:
Employee Name:	Last four digits of employee social security number:		
Employee Home Address (No P.O. Box):	City:	State:	Zip Code:
Employee E-mail Address:			
Employee Home Phone:	Employee Cell Phone:		
Bank Name:	Account Type: Checking Savings		
Routing #:	Account #:		
Care Fund Representative to Complete Grant/Deposit $: ____ Date: ____ Representative Signature			

I authorize the Tenet Care Fund to direct deposit grant funds awarded into my above named bank account.

Employee Applicant Signature:
Date:

Please return this signed form to CareFund@tenethealth.com