SAINT JOHN REGIONAL HOSPITAL FOUNDATION
FONDATION DE L'HÔPITAL RÉGIONAL SAINT JOHN

# Employee Crisis Fund

## Application for Assistance

***Please Note: Situations which do not qualify include lost wages, credit card debt, utility bills (i.e. cable TV), car payments, monthly mortgage payments, child support, attorney fees, garnishments of paycheck for any reason, past due monthly bills or ongoing medical costs and living expenses.***

***This Fund was not established to support an employee financially from losses caused by gambling, overspending or financial mismanagement.***

This information will be detached and remain anonymous.

Application Date: _____

Applicant Name (please print): _____

Or on behalf of: _____

Address: _____

City: _____ Prov. _____ Code: _____

Phone: (h) _____ (c) _____ (wk) _____

Department: _____ Position: _____

Manager/Supervisor's Name: _____

Number of Dependent Children in your Household: _____

Annual Household Income including any other sources of income.

Example: child/spousal support. Etc. _____

_____

Have there been any changes in your monthly income over the past couple of months?

_____

_____

Do you have any extraordinary financial obligations that impact your current financial need?

_____

_____

If any information provided is found to be false, restitution will be sought.
I state that I am eligible for consideration for financial relief from the
Employee Crisis Fund as outlined in the Fund Guidelines.

_____ _____

Applicant Date

# Employee Crisis Fund Application

Amount Requested: $_____(up to $1,000)

Reason for application of emergency funds (please explain the problem in detail)

_____
_____
_____
_____

(Please use additional paper if needed.)

Please attach the receipts you are submitting for consideration and/or any additional information which may assist in the decision making process. Please note, receipts and/or other supporting documentation are mandatory.

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Have you applied for relief from this fund in the past and received aid?

_____No _____Yes

If yes, date(s) and amount(s) granted?

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Have you applied for funds from any other organization for assistance?
(Example: Red Cross, Social Services, Bank Loan, Community Agency, etc.)

_____No _____Yes

If yes, date(s) and amount(s) granted?

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Please return this form and supporting documentation, ***including receipts***, to the Social Work Department, Level 1 of the Saint John Regional Hospital.

**Please add any additional information that will help support your request.**

_____
_____
_____
_____
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_____