SUBJECT:

EMPLOYEE DISASTER FUND AT FMC and SHARE AND CARE AT VVMC

POLICY – FMC

Flagstaff Medical Center (FMC) has established an "Employee Disaster Fund". The purpose of this fund is to financially help those employees who have suffered a financial hardship due to **an emergency or unexpected disaster situation in their lives.**

The Disaster Fund Committee will administer the fund and deny or grant requests.

GUIDELINES

COMMITTEE:
The Disaster Fund Application Review Committee consists of a chairperson, and no more than eight (8) members. Employees must have worked at FMC for at least six (6) months in order to serve on the committee. One of the committee members may act as co-chair and review applications in the chairperson's absence. Members may serve up to two (2) years. After a hiatus of at least one (1) year, committee members may rejoin. The chairperson may act as a chair for no longer than one (1) year.

Employees who wish to join the committee may contact the chairperson who will make the decision to add members if there are vacancies. If the membership drops below eight (8) people, the chair will contact department directors for recommendations.

If a member is unable to attend at least 50% of the application review meetings within six (6) months, the chairperson may drop the member from the committee.

ELIGIBILITY:
Any employee (and/or their immediate family member) who has been employed by FMC for at least six (6) months and has worked a minimum of 520 hours during the previous six (6) month period is eligible. The 520 hours includes PTO and STD.

Maximum allowable assistance is $1,000 per twelve (12) month period. During periods when the fund balance is below $2,000, maximum is reduced to $500 per twelve (12) month period. The $1000.00 limit may be increased with the approval of the Vice President of Development on a case by case basis.

PROCEDURE

Anyone wishing to request funds must complete an application and turn it in to Human Resources with all necessary documentation. The Human Resource Department (HR) will check to assure eligibility. If the employee is deemed eligible, HR will give the application to the Disaster Fund chairperson, co-chair, or designee if the chair and co-chair are unavailable. The chairperson will review the application to assure all necessary documentation is complete and the applicant has suffered an unexpected hardship. The chairperson will contact the applicant to let him/her know that the application was received and may at that time ask for any other information needed or for clarification of the existing information. If the application is incomplete, the chairperson will return it to the applicant for completion.

In order for money to be approved for disbursement, a minimum of three (3) disaster fund committee members must be present, in addition to the acting chairperson.

APPROVED:	DATE REVIEWED/REVISED:
Ray Grossman NAH, Interim Vice President of Human Resources/Education Services	03/15/2013

EMPLOYEE CONTRIBUTIONS:
Employees may contribute two dollars ($2.00) or more per pay check on a voluntary basis to the fund. To contribute, employees submit payroll deduction to Payroll. Employees may also make a lump sum contribution to the fund at any time.

DISBURSEMENTS:
The Disaster Fund Application Review Committee meets as needed to review all applications. A minimum of three (3) Disaster Fund Committee members excluding acting chair must be present. The chairperson will present the information on the application without any information which would identify the applicant. If an application is approved, a check or checks will be written to the agency or company indicated by the employee. Funds will not be given directly to the employee. If approved, funds will be disbursed within two (2) business days of approval.

Attachments: Release of Information Form; Request Form; Payroll Deduction Authorization Form

****Insert FMC Employee Disaster Fund (HR 7-**10)/Release of Information

**** Insert FMC Employee Disaster Fund (HR 7-**10)/Request Form

**** Insert FMC Employee Disaster Fund (HR 7-**10)/Request Form Page 2

**** Insert FMC Employee Disaster Fund (HR 7-**10)/Request Form Page 3

**** Insert FMC Employee Disaster Fund (HR 7-**10)/Request Form Page 4

**Insert FMC Employee Disaster Payroll Deduction Authorization

POLICY – VVMC (VVMC Foundation Policy)

VVMC FOUNDATION has established an Employee Share and Care program. The purpose of this program is to financially help those employees (and/or their immediate family member) who have suffered a financial hardship due to an emergency or unexpected disaster situation in their lives. The Employee Share and Care Application Review Committee will administer the fund and deny or grant requests.

GUIDELINES

COMMITTEE:
The Employee Share and Care Application Review Committee consists of three (3) VVMC Representatives, or their designee(s) as appointed by the Vice President of Development. The Vice President of Development will appoint a chairperson to the committee.

ELIGIBILITY:
Any employee (and/or their immediate family member) who has been employed by VVMC for at least six (6) months and has worked a minimum of 520 hours during the previous six (6) month period is eligible. The 520 hours includes PTO and STD.

Maximum allowable assistance is $1,000 per twelve (12) month period. During periods when the fund balance is below $2,000, maximum is reduced to $500 per twelve (12) month period. The $1000.00 limit may be increased, with the approval of the Vice Pr4esident of Development, on a case by case basis.

PROCEDURE

Anyone wishing to request funds must complete an application and turn it in to the VVMC Foundation with all necessary documentation. The VVMC Foundation will forward to the Share and Care Application Review Committee who will check to assure eligibility. The chairperson will review the application to assure all necessary documentation is complete and the applicant has suffered an unexpected hardship. The chairperson will contact the

applicant to let him/her know that the application was received and may at that time ask for any other information needed or for clarification of the existing information. If the application is incomplete, the chairperson will return it to the applicant for completion. **ALL INFORMATION IS STRICTLY CONFIDENTIAL AND WILL BE KNOWN ONLY TO THE FOUNDATION and the EMPLOYEE SHARE AND CARE REVIEW COMMITTEE.** Payroll will be advised of the award amount, if any, for payroll taxation purposes.

DISBURSEMENTS:
The Employee Share and Care Application Review Committee meets. If an application is approved, a check or checks will be written to the agency or company indicated by the employee. The Committee Chairperson will notify the Foundation of the approval and provide the necessary check request(s). Funds will not be given directly to the employee.

Attachments: Release of Information Form; Request Form; Payroll Deduction Authorization Form
** Insert VVMC Employee Share and Care/Release of Information
** Insert VVMC Employee Share and Care/Request Form (full document)

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

FMC EMPLOYEE DISASTER FUND (HR 7-10) / RELEASE OF INFORMATION

NAME OF EMPLOYEE ____PHONE ____________________

DEPARTMENT __________________________________ SOCIAL SECURITY NUMBER ___________________

Lawson # ________________________________

The purpose of the **EMPLOYEE DISASTER FUND** is to financially help those employees of Flagstaff Medical Center (FMC) who have suffered a financial hardship due to an unexpected emergency or disaster in their lives.

I _____________________________________, give the disaster fund chairperson, or his/her designee, permission to gather information relating to myself and my situation. I understand that this information is to be used to verify the facts that I have discussed below. I understand that this information will only be gathered during the time of my present request. I also understand that if I decline this permission, it will not be held against me in any way, or be cause in itself for my request to be denied.

_____ **YES**, you have my permission to use my name and situation to speak to the following individuals:

HUMAN RESOURCES, to verify:

__________Date of hire
__________Paid time off/disability status
__________History of fund requests
__________Supervisor's input

OTHER INDIVIDUALS/AGENCIES (Please List)

____
____
____
____

_____ **NO**, you may not speak with anyone using my name and situation.

______________________________ ________________________________ ________________
NAME (Please Print) SIGNATURE DATE

PLEASE NOTE: In order to process your application in a timely manner, please include copies of pay stubs for the month for **ALL** members of your household. Also, please include copies of all bills.

* *

TO BE COMPLETED BY HUMAN RESOURCES CONTACT VERIFYING INFORMATION:

I agree to keep this request in strict confidence, and will only mention the name of the requesting employee to the above authorized individuals.

______________________________ ________________________________ ________________
NAME (Please Print) SIGNATURE DATE

* *

TO BE COMPLETED BY DISASTER FUND CHAIRPERSON OR DESIGNEE:

I agree to keep this request in strict confidence, and will only mention the name of the requesting employee to the above authorized individuals.

______________________________ ________________________________ ________________
NAME (Please Print) SIGNATURE DATE

FMC EMPLOYEE DISASTER FUND (HR 7-10) / REQUEST FORM
(Use back for additional information.) PAGE 1

Date of initial request _____ Amount being requested and to whom*_____
*Funds will not be given directly to employee.

NAH hire date_____ Budgeted hours _____ PTO _____ STD _____

Date of last application _____

The disaster fund was set up to help employees who are in the midst of an unexpected disaster. Funds will be granted to companies or agencies as requested by the applicant. Funds will not be granted to employees directly. The committee meets one (1) time per week in order to review applications. Please provide as much information as possible so that the committee can best evaluate your situation.

What was the unexpected emergency or disaster that led you to have financial difficulties? Describe in detail.

_____

_____

_____

What have you been unable to pay? Please include eviction notices and/or utility shut off notices or other documentation if you have it.

_____

_____

_____

Have you contacted other funding sources? (family, community agencies, utility companies) Please list and describe outcome.

_____

_____

_____

Have you attempted to work out any payment plans with creditors? Please list and describe outcome.

_____

_____

Do you have any credit card debt? If so, have you been to credit counseling?

_____

_____

Use back of page if additional space is needed for any additional, pertinent information or comments.

FMC EMPLOYEE DISASTER FUND (HR 7-10) / REQUEST FORM
(Use back for additional information.) PAGE 2

____
Employee LAST FIRST M.I. PHONE #

____
Spouse/significant other LAST FIRST M.I. PHONE #

Number in household: __________ Number of dependents over 18: __________ Are they students?: __________ Number of dependents over 18: __________

Employee monthly take-home pay: $____________ Spouse/significant other monthly take-home pay? $__________

____
Spouse/significant other employer? How long? Phone #

<u>All</u> other sources of income (please specify by circling):
Welfare, AFCD, alimony, Social Security, Workmen's Compensation, annuities, stocks, child support, V.A., National Guard, other military $____________

TOTAL MONTHLY INCOME: $____________

* *

ASSETS: Savings account #______________________________ $______________________
Checking account #______________________________ $______________________
Name of bank(s)____
____
____

- -

Bank credit card #______________________________ Limit $______________________ Balance $____________
Bank credit card #______________________________ Limit $______________________ Balance $____________
Stocks, bonds, other property____ Value $____________

* *

LIVING EXPENSES: **<u>Monthly payments</u>**
Home (circle one) rent buy .... $____________
Utilities per month (unless included in rent) .... $____________
Groceries per month... $____________
If food stamps, how much $__________
Cars & trucks: Make____________________ Year__________ .... $____________
Make____________________ Year__________ .... $____________

Monthly car expenses (gas, oil, repairs) .... $____________
Other expenses (please specify):
____ .... $____________
____ .... $____________
____ .... $____________

Other current debts (medical, dental, pharmaceutical, department stores, loans, etc.)

<u>Name of company</u>	<u>Balance</u>	<u>Monthly payments</u>	<u>Pay-off date</u>
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

The application hereon is, to the best of my knowledge, true and correct. I authorize the hospital to obtain such information it may require concerning the statements made in this application.

Guarantor signature:____ Date:________________

FMC EMPLOYEE DISASTER FUND (HR 7-10) / REQUEST FORM
(Use back for additional information.) PAGE 3

Documentation Requirements:

X	Please provide the following documentation:	To be used by Disaster Fund only.
	Pay check stub from applicant	
	Pay check stub from spouse's/significant other's employer	
	Housing rental agreement or mortgage receipt	
	Electric bill	
	Gas bill	
	Water bill	
	Phone bill	
	Proof of vehicle #1 payment amount	
	Proof of vehicle #2 payment amount	
	Copies of all other bills/payments that you are submitting for payment	

NOTE: Please include all documentation even if you do not think it is pertinent at this time. The disaster fund officer may return the application to you if documentation is not complete. Thank you.

FMC EMPLOYEE DISASTER FUND (HR 7-10) / REQUEST FORM
PAGE 4

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TO BE COMPLETED BY DISASTER FUND CHAIRPERSON/DESIGNEE:

Committee meeting held: Date_____ Time_____

Committee members present:

_____ _____ _____

_____ _____ _____

_____ _____ _____

ACTION TAKEN BY COMMITTEE:

Request denied_____ Request granted_____

Additional information required:_____

_____

_____

Amount granted or help given:_____

Basis for denial:_____

If denied, what suggestions were given to the requestor: _____

REQUESTING PARTY WAS NOTIFIED OF DECISION: Date _____ Time _____

What was their reply?_____

_____

_____

FMC EMPLOYEE DISASTER
PAYROLL DEDUCTION AUTHORIZATION

Flagstaff Medical Center (FMC) has established an Employee Disaster Fund. The purpose of this fund is to financially help those employees who have suffered a sincere hardship that could not have been planned for or anticipated.

The Disaster Fund Committee will administer the fund and deny or grant requests.

Employees may contribute up to $10.00 per paycheck on a voluntary basis. If you wish to contribute, please fill out the following payroll deduction authorization.

I authorize the Payroll Department to deduct each paycheck:

$2.00_____ $4.00_____$5.00_____ $10.00_____

PLEASE NOTE: A one time contribution of any amount up to $260.00 per year is also accepted. If you would like to make such a request, do so below.

$_____

Name (Print Name)_____ Date _____

Lawson # _____

Signature_____

I understand that this deduction will continue until a written cancellation is filed.

_____Cancellation of Disaster Fund Deduction

Name (Print Name)_____ Date _____

Lawson # _____

Signature_____

ALL INFORMATION PROVIDED IS STRICTLY CONFIDENTIAL

VVMC EMPLOYEE SHARE AND CARE/RELEASE OF INFORMATION

The purpose of the **EMPLOYEE SHARE AND CARE** is to financially help those employees (and/or their immediate family member)of Verde Valley Medical Center who have suffered a financial hardship due to an unexpected emergency or disaster in their lives. Funds will be granted to companies or agencies as requested by the applicant. Funds will not be granted to employees directly. Please provide as much information as possible so that the committee can best evaluate your situation.

NAME OF EMPLOYEE _____ PHONE _____ Lawson # _____

DEPARTMENT _____ SOCIAL SECURITY NUMBER _____

I _____, give the Foundation and/or the Employee Share and Care Application Review Committee permission to gather information related to me and my situation. I understand that this information is to be used to verify the facts that I have discussed below. I understand that this information will only be gathered during the time of my present request. I also understand that if I decline this permission, it will not be held against me in any way, or be a cause, in itself, for my request to be denied.

_____ **YES, you have my permission to use my name and situation to speak to the following individuals:**

OTHER INDIVIDUALS/AGENCIES (Please List – use back for additional information)_____

_____

_____ **NO, you may not speak with anyone using my name and situation.**

NAME (Please Print):_____

SIGNATURE :_____ DATE:_____

ALL INFORMATION PROVIDED IS STRICTLY CONDIFENTIAL

VVMC EMPLOYEE SHARE AND CARE / REQUEST FORM

Employee: LAST_____ FIRST_____M.I.___ PHONE #_____

Spouse/significant other: LAST_____ FIRST_____ M.I.___ PHONE #_____

Number in household: _Number of legal dependents over 18: ___ Are they students?:_____

Employee monthly take-home pay: $_____

Spouse/significant other monthly take-home pay? $_____

Spouse/significant other employer? _____How long? _____Phone #_____

Employee VVMC hire date_____ Budgeted hours _____ PTO _____ STD _____

Date of last (previous) application (if applicable): _____

What was the unexpected emergency or disaster that led you to have financial difficulties? (Describe in Detail)_____

_____

What have you been unable to pay? Please include eviction notices and/or utility shut off notices or other documentation if you have it._____

_____

_____

Have you contacted other funding sources? (family, community agencies, utility companies) Please list and describe outcome._____

_____

_____

Have you attempted to work out any payment plans with creditors? Please list and describe outcome.

_____

_____

Do you have any credit card debt? If so, have you been to credit counseling?_____

Use back of page if additional space is needed for any additional, pertinent information or comments.

Date of initial request _____ Amount being requested and to whom*_____

_____

*Funds will not be given directly to employee.

All other sources of income (please specify by circling): Welfare, AFCD, alimony, Social Security, Workmen's Compensation, annuities, stocks, child support, V.A., National Guard, other military $_____

TOTAL MONTHLY INCOME: $_____

ASSETS: Savings account #_____ $_____

Checking account #_____ $_____

Name of bank(s)_____

_____

Bank credit card #_____ Limit $_____Balance $_____

Bank credit card #_____ Limit $_____Balance $_____

Stocks, bonds, other property_____ Value $_____

LIVING EXPENSES: Monthly payments

Home (circle one) rent buy..... $_____

Utilities per month (unless included in rent) ..... $_____

Groceries per month ..... $_____

If food stamps, how much $_____

Cars & trucks: Make_____ Year_____ ..... $_____
Make_____ Year_____ ..... $_____

Monthly car expenses (gas, oil, repairs) ..... $_____

Other expenses (please specify):
_____ _____ ..... $_____
_____ ..... $_____
_____ ..... $_____

Other current debts (medical, dental, pharmaceutical, department stores, loans, etc.)

Name of company	Balance	Monthly payments	Pay-off date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The application hereon is, to the best of my knowledge, true and correct. I authorize the hospital to obtain such information it may require concerning the statements made in this application.

Guarantor signature: _____

Date:_____

Documentation Requirements: Please provide the following documentation to be used by Share and Care only.

_____Pay check stub from applicant

_____Pay check stub from spouse's/significant other's employer

_____Housing rental agreement or mortgage receipt

_____Electric bill

_____Gas bill

_____Water bill

_____Phone bill

_____Proof of vehicle #1 payment amount

_____Proof of vehicle #2 payment amount

_____Copies of all other bills/payments that you are submitting for payment

NOTE: Please include all documentation even if you do not think it is pertinent at this time. The Employee Share and Care officer may return the application to you if documentation is not complete. Thank you.

PLEASE NOTE: In order to process your application in a timely manner, please include copies of pay stubs for the month for ALL members of your household. Also, please include copies of all bills.