The Community Foundation of Middle Tennessee

The Dare to Care Employee Assistance Fund

APPLICATION FOR ASSISTANCE

THE PROGRAM: The Fund helps **Correct Care Solutions or ConMed Healthcare Management** employees or eligible dependents who are experiencing serious economic hardship and are unable to afford basic living needs because of a **natural** disaster, life-threatening illness or injury, death, or other catastrophic circumstances beyond the employee's control.

ELIGIBILITY: All **Correct Care Solutions or ConMed Healthcare Management** employees who are 1) regularly scheduled to work 20 or more hours per week; 2) employed by Correct Care Solutions or its affiliates working and residing in the U.S.; 3) employed for at least six months prior to this application; and 4) actively employed or on an approved leave of absence for no more than one year are eligible for grants from The Dare to Care Fund. **In the case of death of the employee, then spouse or eligible dependents may apply.** A copy of your paystub or payment statement should be attached to help verify employment. An employee can only be approved for assistance once within a 12-month period.

GRANTS: The maximum grant amount available for assistance is $2,500.00. The maximum award is not guaranteed, and in some cases, a lesser amount will be awarded. **All assistance grants are made directly to vendors as bill payments; no assistance funds are sent directly to applicants.**
Community Foundation staff is available to assist all applicants in this process. Call 615-321-4939 ext. 115 with questions.

SECTION A: WILL YOU QUALIFY?

To qualify for this program and receive assistance you must meet all 3 of these requirements:

- ☐ You must be currently employed by Correct Care Solutions or ConMed **and** have been employed for at least six months.
- ☐ The qualifying incident must have happened within the past 60 days.
- ☐ Your situation MUST fall into one of these four categories: *(check the one below that describes your situation)*

☐ **Natural Disaster:** For situations, such as a wildfire, flood, tornado, hurricane, severe storms or earthquake, that have damaged or destroyed the employee's primary residence. The Fund 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.*

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

☐ **Death Incident:** This includes the death of the employee, spouse or eligible dependent(s). The loss of income, cost of burial or funeral expenses, or resulting medical bills prevents an employee or the employee's family from affording basic living expenses. The Fund may be able to help pay expenses to bring a child whose parents have died to live elsewhere. The Fund cannot pay for travel to funerals, caskets, grave markers or other funeral expenses*. Copy of the death certificate or obituary will be required.*

☐ **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, extreme vandalism), or another reportable incident beyond the employee's control that impacts the ability to afford basic needs. Catastrophic or extreme circumstances **do not include:** credit card debt, home foreclosure, wage garnishment, bankruptcy, child support payment, car repair, taxes, or accumulated financial distress. *Police, Fire or other official incident report may be required.*

SECTION B: YOUR GENERAL INFORMATION

Applicant Name (please print clearly): _____

Permanent Address: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

Daytime Phone: (_____) _____ Is it okay to leave you a message? ☐YES ☐NO

Other Phone: (_____) _____ Is it okay to leave you a message? ☐YES ☐NO

Current Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____ ** Approval notification is sent to you by mail, so please provide a valid mailing address **

Where are you employed? _____ City: _____ State: _____

CIRCLE ONE: Correct Care Solutions Employee Conmed Employee Job Title: _____

Date of Hire: _____ Supervisor's Name: _____

Employee Name (please print clearly): _____

SECTION C: DESCRIBE YOUR SITUATION

Which qualifying situation caused the financial hardship? (Read the descriptions on page 1 in **Section A**. Circle the category **below** that best fits your situation. *Call 615-321-4939 ext. 115 with questions.)*

Natural Disaster **Life-Threatening Illness or Injury** **Death Incident** **Catastrophic or Extreme Circumstances**

Name of Incident: _____ Date of Incident: _____
(example: tornado, fire, flood, type of injury, name of illness, domestic abuse) **(must be within past 60 days)**

Who has been affected by the situation? _____

Is the affected person covered by medical or disability insurance? _____ Have they applied for disability benefits? _____

If your home was damaged, will insurance cover part of the cost? _____ Your deductible amount? _____

How many people live in your household: _____ Number of adults: _____ Number of children: _____

Describe the incident in detail: What happened? _____

_____

_____

_____

Describe how the incident has caused your financial hardship: How has this made it hard to afford your basic living needs?

_____

_____

_____

_____

Estimate the financial impact of the incident: How much has this cost you? _____

_____

_____

_____

Please tell us anything else that would help us understand the hardship you or your family are experiencing. **If this application is being completed by someone other than the employee (as in the case of death or other inability to complete the form), please explain and provide a contact name and information.** _____

_____

_____

_____

Have other resources been considered or used, such as American Red Cross, Salvation Army, or other similar social service agencies? Please comment on efforts and response: _____

_____

_____

Employee Name (please print clearly): _____

SECTION D: ASSISTANCE GRANTS

Grants are only to help pay for limited types of essential living expenses, which are:

- Rent, mortgage or other housing payments
- Temporary housing and security deposits for new housing
- Essential utility bills (electricity, heat, water, etc.)
- Medical expenses (bills), not eligible for reimbursement or covered by insurance
- Minor home repairs needed to maintain home safety
- Travel for minor children required to relocate following the death of parent/guardian

Grants cannot be made to pay for other expenses such as:

- Legal fees
- Insurance premiums or deductibles
- Non-essential utilities (cable, phone, etc.)
- Car payments or repairs
- Furniture, appliances, electronics
- Funeral expenses or grave markers
- Accumulated financial issues or credit card debt
- Accidental damages due to negligence

If the application is approved, The Community Foundation of Middle Tennessee will make the grant(s) in the form of check(s) payable to the vendor(s) and the applicant will be notified of the payment(s) by mail. **All grants 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, the account number (when relevant), amount due, and due date. Remember, although the maximum grant amount is $2,500, smaller sums may be awarded, so list the vendors in order of priority. **For each vendor, attach appropriate documentation (bills, lease, mortgage coupon, account statement, etc.)**

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

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

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

NOTE : We cannot make payments without clear, complete information including full account numbers and documentation. Omitting copies of your bills will delay your application.

Employee Name (please print clearly): _____

Application Checklist:

Did you remember the following:

- ✓ Carefully read the requirements to see if you qualify
- ✓ A copy of your paystub or payment statement (to help verify employment)
- ✓ Complete Sections A-D of the application
- ✓ Check Section D that your grant requests are allowed by the program
- ✓ Sign Section E: Declarations and Agreement page
- ✓ Attach copies of documentation such as: bills, leases, mortgage coupon or statement
- ✓ Include all required documentation (medical, police & fire reports, obituaries, etc…)

SECTION E: DECLARATIONS AND AGREEMENT

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

This application will be treated in a confidential manner by The Community Foundation of Middle Tennessee; however non-identifying statistical information will be reported to Correct Care Solutions or ConMed Healthcare Management on a periodic basis.

Employees are expected to provide truthful and accurate information. In its due diligence, if The Foundation discovers any information to be untrue, it shall have the right to unilaterally waive its confidentiality and report its findings to the Company. The fiduciary expectations of all Correct Care Solutions or ConMed Healthcare Management employees are paramount and a breach of these standards will be reported to Correct Care Solutions or ConMed Healthcare Management.

Your signature below certifies that the information provided is true and complete, authorizes The Community Foundation to obtain and/or verify all information necessary to process this application, and releases Correct Care Solutions, ConMed Healthcare Management and The Community Foundation of Middle Tennessee from any liability associated with the rejection of or funding of this application. Remember that the maximum amount any employee or family member can receive in a 12-month period is $2,500. It is likely that, from time to time, lesser amounts will be awarded. In addition, you agree to provide the requested documentation supporting the information provided.

Applicant's Signature: _____ Date: _____

Each application for a grant must include:

- Assistance Application
- Vendor documentation (bills to be paid)
- A copy of the death certificate or obituary notice if Death Incident
- Police, Fire, or other official incident report if for Catastrophic Circumstances
- Medical documentation if needed
- Copy of paystub or payment statement

Mail or fax completed and signed application with requested documentation to:

The Dare to Care Employee Assistance Fund
The Community Foundation of Middle Tennessee
3833 Cleghorn Avenue, Suite 400
Nashville, TN 37215
Phone: 615-321-4939
Fax: 615-327-2746