Platte Valley Medical Center Foundation

Humanitarian Program (EAF) Guidelines and Procedures

Program Description
The purpose of the Humanitarian Fund is to provide interest free funds to associates for emergencies and financial hardships. The Humanitarian Fund is funded entirely by donations; donors include physicians, associates and former loan recipients. ALL REQUESTS FOR ASSISTANCE WILL BE HELD IN THE STRICTEST CONFIDENCE.

Humanitarian Funds of **up to $1,000** are available for **HARDSHIPS & EMERGENCIES ONLY.** Applications will not be considered for vacations or educational expenses. The Humanitarian Fund Committee determines if a request for assistance meets the criteria on a case-by-case basis. Checks will be made payable directly to the vendor providing the service, and a vendor invoice must be provided. Loan proceeds are never paid directly to individual associates.

QUALIFICATIONS: Associates must meet each qualification to be eligible for a loan.

Associate must have been employed by SCL Health/Platte Valley Medical Center full- or part-time for at least six (6) months and be in good standing. Human Resources will be contacted to determine employment status. In **NO** instance will the loan be approved if the associate has any active corrective action outstanding.

Associates may only take out one loan in any 12-month period. Associates with an outstanding loan balance are not eligible. To check the balance of an open loan, or to determine the date of your last Humanitarian Loan, please contact the Platte Valley Medical Center Foundation at 303-498-3630 or carol.baumgartner@sclhealth.org.

The loan must be repaid through automatic payroll deduction. A minimum of $30.00 per pay period or $60.00 per month will be deducted from the associate's paycheck, beginning immediately after the loan is issued and until the loan is repaid in full. ***Please note: payroll deductions are made each pay period. If you are PRN or miss a standard pay period, the total of missed repayments will be deducted in full from your next paycheck.*** **(i.e. If you do not work for three pay periods, $90 will be deducted from your next paycheck for loan repayment.)** Repayment may not be deferred until a later date, unless otherwise stated by the Humanitarian Fund Committee. In the event that there are three pay periods in a given month, loan repayment will not be deducted from the third paycheck issued in that month.

If the associate's employment is terminated for any reason, or if the associate's employment status changes from full- or part-time to "on call" before the loan is repaid in full, the outstanding amount of the loan will be deducted from the associate's final paycheck.

Applicants are required to meet with the WorkLife Partnership Navigator, Nathan Crow, to discuss your situation and explore additional resources. WorkLife Partnership is an associate benefit program and its resources are free to SCL Health associates. To schedule your phone call or in-person meeting, please call Nathan at 303-589-7412 (texts accepted) or e-mail at ncrow@worklifecolorado.org.

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APPLICATION PROCESS: Follow all steps. Incomplete applications will not be reviewed.

Step 1. Pick up the Humanitarian Fund application from the Community Relations/Chaplain's office or Platte Valley Medical Center Foundation, located at 1600 Prairie Center Parkway, Brighton, CO 80601 or call Daryl Meyers at 303-498-1590 or Carol at 303-498-3630 to have the application mailed to you.

Step 2. Schedule a meeting with the WorkLife Partnership Navigator, Nathan Crow, to discuss your situation and explore additional resources. WorkLife Partnership is an associate benefit program and its resources are free to SCL Health associates. To schedule your meeting, please call Nathan at 303-589-7412 (texts accepted) or e-mail at ncrow@worklifecolorado.org.

Step 3. After meeting with WorkLife Partnership, please review and fully complete the attached application, and include a copy of the bill(s), rent lease, etc. for which you are requesting hardship assistance.

Step 4. Deliver application to 1600 Prairie Center Parkway, Brighton, CO 80601 or email it to Daryl.Meyers@sclhealth.org or Carol.Baumgartner@sclhealth.org. Loan payments must go directly to a vendor (landlord/property management company, utility company, business, etc.) and documentation of the amount to be paid must accompany the application. If you have any questions or to make an appointment with a Humanitarian Fund representative, please contact Daryl at 303-498-1590 or Carol at 303-498-3630.

Step 5. The Humanitarian Representative will determine eligibility. If the associate meets all eligibility criteria, the application will be forwarded to the Humanitarian Fund Committee for final review and approval.

Step 6. You will be notify after a decision is made.

APPROVED LOANS AND GRANTS:
Once approved, Foundation staff will prepare check(s), payable to vendors included on the application. The approval process may take up to three (3) business days. Holidays and weekends may extend this time period. Staff will notify associates when checks are ready to be picked up. Associates are responsible for delivering or mailing checks to vendors.

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Humanitarian Program (EAF)
Confidential Information

Today's Date: _____

TOTAL AMOUNT REQUESTED: $_____

Date check needed*: _____

* Please note: the loan or grant approval process may take up to three (3) business days.

Name of Applicant (Please print): _____

Care Site/Office Location: _____

Department/Unit Name:	Work Phone:
Position Title:	Lawson ID # (**REQUIRED**):
Shift:	Immediate Supervisor:
Length of Employment at SCL Health:	Supervisor's Phone:
Employment Status (circle one): Full-time Part-time	Is it okay to leave a voicemail on your home/cell phone? ☐ Yes ☐ No
Applicant Home Phone:	Applicant Cell Phone:
Applicant Home Address: City: State: Zip:	

Please describe, in detail, the hardship or emergency situation for which you need assistance. Continue on back side of this page, if necessary:

_____

_____

_____

_____

Have you previously asked for help from the Humanitarian Fund (EAF)? (Yes/No): _____

If yes, how much was your loan or grant and what was the date you received the loan? _____

LOAN REPAYMENT SCHEDULE: A <u>minimum</u> of $60.00 per month ($30 per pay period) will be deducted from each pay check, commencing on the first pay period following loan approval. *Please note: payroll deductions are made each pay period. If you are PRN or miss a standard pay period, the total of missed repayments will be deducted in full from your next paycheck.* (i.e. If you do not work for three pay periods, $90 will be deducted from your next paycheck for loan repayment.)

Amount to be deducted per pay period: $_____

SIGNATURE OF APPLICANT: _____

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Humanitarian Program (EAF)
Confidential Information

Financial Statement

Date (MM/DD/YYYY): _____

Name of Associate (please print): _____

Care Site: _____

How many in household including yourself? _____ Status (circle one): Single Married Divorced Other_____

Number of dependents: _____ Ages of dependents: ____ _____ ____ ____ _____

Take home pay (self): $_____/month Take home pay (others in household): $_____/month

Other income (self): $_____/month Other income (others in household): $_____/month

Bank Accounts:

Checking (Name): _____ Current balance: $_____

Savings (Name): _____ Current balance: $_____

Monthly expenses:	**Monthly amount:**	**Balance owed:**
Rent/Mortgage payment:	$_____	$_____
Utilities:	$_____	$_____
Telephone:	$_____	$_____
Other: _____	$_____	$_____
Other: _____	$_____	$_____

Other Expenses:	**Monthly amount:**	**Balance owed:**
Bank Loan (Name of Bank) _____	$_____	$_____
Credit Card (Name) _____	$_____	$_____
Department Store (Name) _____	$_____	$_____
Other (Name) _____	$_____	$_____

Are you current on all other monthly bills (circle one)? Yes No

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Humanitarian Program (EAF)
Payroll Deduction Form

(Please print/type)

Associate Name: _____ **Date:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Lawson ID # (REQUIRED) : _____ **Department:** _____

Care Site: _____

I hereby certify that I have received a loan of $ _____ from the Platte Valley Medical Center Humanitarian Fund. I authorize my employer, SCL Health/Platte Valley Medical Center, to deduct loan repayments from my wages until the entire loan amount has been repaid.

I understand that loan repayments must be at least $60 per month (or $30 per pay period) but that I may choose to repay my loan at any amount above that minimum. I understand that only the first and second pay period in any given month will include a loan repayment deduction. I understand that if my employment at SCL Health/Platte Valley Medical Center ends before my loan is repaid, the entire loan balance will be deducted from my final paycheck. Further, I understand that if my employment status changes to on-call, I will immediately contact my care site foundation to make loan repayment arrangements.

Amount to be withheld from each paycheck (minimum of $30 per pay period required): $_____

I understand that SCL Health retains and may exercise the right to pursue all remedies available in law or equity to secure full payment and subsequent fees.

_____ _____
Associate Signature Date

Associate Work Phone: _____ Home Phone: _____

Emergency Contact Name: _____

Contact Home Phone: _____ Contact Second Phone: _____

Relation to Associate: _____