The Foundation

East Jefferson General Hospital

Humanitarian Fund Assistance Application*

Humanitarian Fund Member? Yes_____ No_____ Have you been a member longer than 6 months? _____

Effective Date of Membership_____ Length of Service at EJGH_____ Interview Date_____

Name_____ Address_____ _____

City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Other Phone/Pager_____

Position_____ Department_____ Supervisor_____

Social Security Number_____ Part-time_____ Full-time_____ Other_____

Referral Source_____

Previous Use of Humanitarian Fund? Yes_____ No_____ (If yes, complete below.)

	Date	Money Used For	Amount
1.	_____	_____	$_____
2.	_____	_____	$_____
3.	_____	_____	$_____

Describe catastrophe and give reason assistance is needed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

* Proposed Fund Need: Total Financial Need: $_____ Amount Requested: $_____

Members of Household: List all persons living with you.

	Name	Age	Relationship	Employer
1.				
2.				
3.				
4.				
5.				
6.				

INCOME Income for all Persons in Household (List Gross Amount per Month)		EXPENSES (Monthly Expenses – List Amount per Month)		
Self	$	Rent	$	
Self (second job)	$	House Payment	$	
Spouse	$	Utilities	$	
Spouse (second job)	$	Phone	$	
Roommate	$	Insurance	$	
Child Support	$	Child Support	$	
Alimony	$	Alimony	$	
Retirement	$	Food	$	
Disability	$	TOTAL	$	
			MONTHLY	TOTAL DEBT
Medicaid	$	Department Stores	$	
Food Stamps	$	VISA	$	
Other	$	MasterCard	$	
TOTAL	$	Other Credit Cards	$	
		Furniture	$	
ASSETS		Appliances	$	
Savings	$	Automobile	$	
Investments	$	Medical Doctor	$	
Credit Union	$	Hospital	$	
Tax Sheltered Annuity	$	Loans	$	
PDOs	$	Other	$	
Sick Days	$	TOTAL		
Other	$			
TOTAL	$	GRAND TOTAL OF EXPENSES	$	

If Illness/Accident is Involved, Please List:

Type of Illness/Accident:_____

On-the-Job Injury? Yes_____ No_____ If Yes, Please Explain:_____

Hospitalization Dates:_____ **Doctor's Name(s):**_____

Time Off from Work (dates):_____ **Available Sick Time:**_____

Date of Last Paycheck:_____ **Anticipated Benefits:**_____

Types of Insurance Coverage You Currently Have (*e.g.*, Health, Homeowners, Auto, Disability):_____

_____

Team Members SHOULD Take The Following Actions (If Applicable), Prior To Submitting This Application For Review				
LISTED BELOW ARE MANY CONTACTS THAT MAY BE ABLE TO PROVIDE YOU WITH ASSISTANCE. HAVE YOU CONTACTED ANY OF THE FOLLOWING?	**YES**	**DETAILS OF RESPONSE RECEIVED**	**NO**	**REASON YOU DID NOT CONTACT FOR ASSISTANCE**
Creditors				
Insurance Company				
FEMA				
Red Cross				
Credit Union				
Lending Agencies				
Legal Assistance				
Employee Assistance Program				
Credit Counseling				
Shelters				
Community Service Agency (specify)				
Food Stamps				
Disability Application Filed				
Church Contributions				
Others				
Other Comments				

I agree to accept Humanitarian Fund help if appropriated and available. I certify the information given is true and correct to the best of my knowledge. I understand that all information contained within this application will remain confidential and will be reviewed only by those individuals who are involved in fund administration and who have a specific need to know.

_____ _____

Signed **Date**