ENLOE HEALTH FOUNDATION

Do Not Write in this Area
Application # _____
Date Received _____

ENLOE CARE FUND APPLICATION

The Enloe Care Fund was established to provide financial support for caregivers of Enloe Health (and its affiliated partner companies) during certain qualified emergencies.

Many individuals and families experience unexpected expenses such as a car repair or household bills in amounts higher than expected. The Enloe Care Fund was not established to help in these situations. It was established to help with tragic or catastrophic situations. Please see the Enloe Care Fund Policy for eligibility and criteria.

Only one grant per household will be made to an applicant within a 24-month calendar period. Caregivers with documented catastrophic circumstances may be eligible for additional grant opportunities.

Application will only be considered if all supporting documentation is included. Documentation will vary depending on the nature of the financial crisis and the specific request for funds. All applications will be kept confidential and your name will not be shared with the Enloe Care Fund committee.

Applicant Name_____ Employee ID# (if applicable)_____

☐ Enloe Health Employee ☑ Physician ☐ Partner Organization Employee

Job title_____ Department_____ Supervisor_____

Best Contact Number_____ Email_____

Current Address_____

Do you have a spouse or dependent family member who is also eligible to receive relief funds (e.g., they also work for Enloe or affiliated partner company)?

☐ Yes ☐ No ☐ N/A

If Yes, please complete only one application for your household

Name of Spouse or Dependent Family Member_____

Have you received Enloe Health Foundation Grant Funds in the past? ☐ Yes Amount $_____ ☐ No

Specific amount you are requesting: $_____

Purpose of funding requested_____

Funding Request

Please share what information you are comfortable with regarding the circumstances that led to this situation. Please describe what your financial need is and detail the specific amount you are requesting. **Funds may only be granted if supporting documentation for the request are included (rental agreement, invoice, bills, etc.).**

Please use this space if there is anything else you would like the Enloe Care Fund Committee to know that will help us understand your situation and funding request.

I certify that all statements made in conjunction with this application are true and that any misrepresentation on this application may be sufficient cause for rejection of this or subsequent applications, and disciplinary action.

I also acknowledge that any funds awarded to me may be taxable income. The Enloe Health Foundation recommends you seek advice from a tax professional regarding the handling of any funds awarded.

Applicant's Signature_____ Date_____

Please return completed form and all additional documentation to the Human Resources office or email to HR@enloe.org.

*******FOR FUND APPROVAL COMMITTEE USE ONLY*******

❒ Approved ❒ Denied Date_____ Amount of Distribution $_____

Other actions/follow-up/resources_____