Cape Cod Healthcare Employee Hardship Program
Application for Assistance

(To be submitted to Cape Cod Healthcare Foundation Office, c/o Beatrice Gremlich, P.O. Box 370, Hyannis, MA 02601 – or – via email to: bgremlich@capecodhealth.org)

Applicant Information	
Last Name	**First Name**
Street Address	
City, State, Zip	
Phone Number	**Email Address**
Relationship to Beneficiary ☐ Self ☐ Co-Worker ☐ Family Member	**Applicant Employment Information** CCHC Entity: Job Title: Employment Status:

Beneficiary Information (if other than Applicant)	
Last Name	**First Name**
Street Address	
City, State, Zip	
Phone Number	**Email Address**

Acknowledgements

Please initial the statements below.

_____ I understand that Cape Cod Healthcare will take reasonable measures to protect my privacy. However, I understand that my anonymity cannot be guaranteed.

_____ I understand that funds may not be available at this time and that my application does not guarantee approval of funds.

_____ I have provided supporting documentation and agree to provide additional information that may be requested by the Fund Review Committee.

Reason for Application

The Beneficiary has experienced the following:

☐ Death of employee or family member
☐ Severe illness or accident
☐ Uninsured losses caused by fire, crime, or other disaster
☐ Other

Please provide any information to help the Fund Review Committee make a decision. Please note that you are not required to provide personal information that would prove embarrassing or cause added emotional stress. This section should serve only to clarify your situation and support your application. Attach additional pages if necessary.

You are required to substantiate your incident. Please attach documentation associated with the reason for the application. This may include but is not limited to:

- Certification of medical condition
- Death certificate
- Obituary
- Medical bills
- Insurance claims
- Police reports
- Expense receipts
- Foreclosure or eviction notice
- Any outstanding bills intended to be paid with Hardship Assistance award

Is there insurance that would help in this situation?

☐ Yes ☐ No

If yes, has a claim been submitted?

☐ Yes ☐ No

Describe how the incident prevents you from meeting your financial obligations.

Personal Finances

Because the Fund is limited, applicants should seek assistance from others sources before applying for Fund assistance. Applicants must demonstrate a temporary financial hardship that cannot be met by other means and is caused by a qualified incident. To assist with the evaluation of each request, applicants must submit personal finance information that shows a picture of the family's finances.

Your Assets:	**Your Monthly Household Income:**	**Your Monthly Living Expenses:**
Cash $_____	Your monthly wages $_____	Rent/Mortgage $_____
Savings $_____	Spouse's monthly wages $_____	Utilities $_____
Real Estate $_____	Child support received $_____	Food $_____
Vehicles $_____	Disability insurance $_____	Child support owed $_____
Total $_____	Social Security/Pension $_____	Medical expenses $_____
	Other income $_____	Car loans $_____
	Total $_____	Gas/Incidentals $_____
		Other $_____
		Total $_____

Amount of Assistance Requested

Amount: $_____

What the funds will be used for: _____

Applicant Signature: _____

Date: _____

For Fund Review Committee Use Only

☐ Approved
☐ Not Approved