Print Form

Request #: _____

Date Received: _____

EMPLOYEE EMERGENCY ASSISTANCE PROGRAM REQUEST APPLICATION FORM

DATE OF APPLICATION _____ HOW SOON IS ASSISTANCE NEEDED _____

NAME OF PERSON SUBMITTING REQUEST: _____

PHONE: (H) _____ (W) _____

NAME OF PERSON NEEDING ASSISTANCE: _____

PHONE: (H) _____ (W) _____

ADDRESS: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ OTHER

SPOUSE AND DEPENDENTS NAMES (AGES OF DEPENDENTS PLEASE):

_____ _____

_____ _____

_____ _____

WHAT ARE THE REASONS FOR REQUESTING THIS TYPE OF ASSISTANCE (BE AS SPECIFIC AS POSSIBLE)?

_____

_____

_____

_____

_____

_____

_____

WHAT OTHER AGENCIES HAVE YOU TRIED AND WHAT WAS THEIR RESPONSE? _____

_____

IF REQUESTING FINANCIAL ASSISTANCE WHO SHOULD THE CHECK BE MADE OUT TO? _____

_____

ACCOUNT HOLDER: _____ ACCOUNT #: _____

ADDRESS: _____

STATEMENT/BILL ATTACHED: ☐ YES ☐ NO DATE DUE: _____

ACTION TAKEN: _____

I HEREBY STATE THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO REALIZE THAT FALSIFYING ANY INFORMATION WILL JEOPORDIZE MY ELIGIBILITY.

_____

(SIGNATURE)

St. Peter's Hospital

(COMMITTEE COMMENTS ARE ON THE REVERSE SIDE)