CONFLUENT HEALTH EMPLOYEE FOUNDATION
APPLICATION FOR FINANCIAL ASSISTANCE

In order to request financial assistance, I understand that I must have been employed by a Confluent Health Company for at least 6 months and that any grant may be taxable income at my current rate of pay.

SECTION 1 - EMPLOYEE INFORMATION:

Name: _____

Address: _____

Phone Number: _____ Email Address: _____

Company: _____ Clinic or Office Location: _____

Clinic Director/Manager: _____

Month, Date & Year of Employment: _____

SECTION 2 - DESCRIPTION OF HARDSHIP:

I am applying today as a result of: Natural Disaster Financial Hardship

Date of Natural Disaster or Financial Hardship: _____

Are you currently receiving short or long term disability? _____

Do you or a member of your family have insurance coverage or any other financial assistance during this hardship? If yes, explain. _____

_____

Description of your hardship (include a description of your expenses and/or damage to your essential property): . _____

_____

_____

SECTION 3 - AMOUNT OF ASSISTANCE REQUIRED:

I am requesting a grant of _____ dollars.

Provide an itemized list of your assistance requested with a short description and actual or estimated cost of each item:

SECTION 4 - YOUR FINANCIAL RESOURCES AND OTHER EXPENSES:

List all members of your household, their age, and relationship to you:

Provide your monthly household income:

SECTION 4, CONTINUED:

Provide your monthly household expenses:

Homeowner's or Renter's Insurance (Complete if request is related to loss of primary residence):

Do you own or rent?	Own	Rent
Do you have homeowner's or renter's insurance?	Yes	No
If yes, is this loss covered?	Yes	No
Is the loss due to federally declared national disaster?	Yes	No
If yes, have you applied for FEMA assistance?	Yes	No

Amount of anticipated assistance: _____

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SECTION 4, CONTINUED:

Auto Expenses (Complete if request is automobile related):

Do you have auto insurance? Yes No

If yes, is this loss covered? Yes No

Will auto insurance cover medical expenses? Yes No

Will auto insurance cover lost wages? Yes No

Medical Expenses (Complete if request is related to medical expenses):

Do you have medical insurance? Yes No

If yes, what is the amount of your annual deductible? _____

If no, what is the amount of anticipated government assistance? _____

Have you applied for financial assistance through your medical provider and/or hospital? Yes No

If yes, what is the amount of anticipated assistance? _____

Funeral Expenses (Complete if request is related to funeral expenses):

Is life insurance available? Yes No

Will funds be available from decedent's estate? Yes No

Total assistance family members can provide: _____

SECTION 5 - REQUIRED DOCUMENTATION:

- ☐ Attach a copy of completed insurance claim form, if applicable
- ☐ Attach documentation that substantiates your inability to meet monthly expenses in Section 4.
- ☐ Attach copies of estimates and/or pictures.
- ☐ Attach a police report for car accidents, thefts, or domestic violence.

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Please sign and verify that the information is accurate to the best of your ability:

x _____