

# Maricopa Health Foundation

## Policies & Procedures

### Helping Hands Fund

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#### **Purpose:**

MIHS and the Maricopa Health Foundation are committed to helping its employees during times of financial hardship created by crisis situations. The purpose of the Helping Hands Fund is to provide emergency financial assistance to eligible employees who have incurred a qualifying event as defined in this policy.

#### **Definitions:**

Eligible Employee. Any PT or FT employee regularly scheduled to work 20 or more hours per week and have successfully completed their initial probationary period. Temporary, Contract and Travelers are not eligible.

Good Standing. An employee who met standards on their current performance evaluation and has not received any written disciplinary action in the previous twelve (12) months.

Qualifying Event. Unanticipated significant events such as illness, injury, death, natural disaster, etc.

Crisis. An unexpected situation or sudden unplanned/unforeseen event or occurrence which is serious and urgent and which demands immediate action.

#### **Policy:**

This policy establishes the guidelines for provision of emergency financial assistance to eligible MIHS employees in good standing who cannot meet expenses arising from unanticipated health and/or other crisis situation as described above. Specifically, this program is meant to provide financial assistance to eligible employees to meet basic needs such as housing, utilities, clothing and funeral expenses due to a natural disaster, illness, injury or death.

#### **Monetary Limits:**

An employee who is eligible and meets the qualifying criteria may only receive financial assistance once within a 12-month period with the maximum amount of each incident being \$500.00 and a lifetime maximum of \$1000.00. No more than one application per employee per crisis situation may be submitted. Employee may not reapply within 6 months of application whether approved or denied. Helping Hands is only intended to assist with basic needs such as housing, utilities, clothing and funeral expenses. Costs associated with travel to/from a funeral are not covered.

**Fund Distribution:**

The fund will be administered by the Chaplaincy Department. Information will be kept in a confidential manner.

No distribution shall be made from the Fund directly to an individual.

While Funds are made available to assist all eligible MIHS employees, it will be the final determination of the Chaplaincy Department to determine if the application and funds are approved. This decision will be based upon all information provided in the application. All decisions are final and are not subject to appeal.

**Application Process:**

Eligible employees should complete the following application process:

- A. Schedule appointment with Chaplaincy Department.
- B. If eligible, employee will be responsible for completing necessary forms pertaining to event, provide all required supporting documentation and submit in person. Information is confidential
- C. If the application is approved for assistance, checks are made payable directly to the creditor on behalf of the employee.

**Required Documentation:**

At the time of application, the following information is necessary:

- The last 2 consecutive pay stubs for the employee.
- Official documentation of the incident, which has created the financial hardship or any other documentation which will support the case for emergency assistance.
- (I.e. physician's statement; accident, police or fire report; death certificate; etc.)
- Copy of the bills or statements to be paid by the Helping Hands Fund. These items must include the names of who the checks are to be made payable and the mailing addresses.

**Expenses Not Eligible for Helping Hands Funding**

Payments from the Helping Hands Fund are intended to assist employees unable to meet actual emergency, essential expenses. Funds are not available for the following items or losses or other items not considered essential:

- Requests to cover health insurance premiums, health plan co-payments, medical and/or insurance deductibles. Medical expenses covered by insurance.
- Requests for financial assistance to maintain current wage levels and/or recover lost wages.
- Vehicle or vehicle insurance payments
- Credit card payments
- Cable television, cellular phone/pagers, telephone features such as caller ID, voice messaging, etc.
- Funeral travel expenses and non-essential funeral items – flowers, acknowledgements, limousines, grave markers, etc.

MARICOPA HEALTH FOUNDATION  
*Helping Hands Fund*

**Confidential Crisis Assistance Request Form**

***SUBMIT COMPLETED FORM TO: Chaplain's Office, Main Hospital, 1<sup>st</sup> Floor, or Chaplain's Office, Desert Vista. Clinic employees should inter-office forms to Chaplain's Office, Main Hospital, 1<sup>st</sup> Floor.***

*Please print*

|  |  |
|--|--|
| <b>Name</b>                                |  |
| <b>Daytime Phone</b>                       |  |
| <b>Address</b>                             |  |
| <b>Employee Number and Department Name</b> |  |
| <b>Manager's Name</b>                      |  |
| <b>MIHS Hire Date</b>                      |  |

I request assistance in the amount of \$\_\_\_\_\_ from the **Helping Hands Fund** due to the crisis situation described below or on the attached page.

I have attached copies of the bills to be paid by the Helping Hands Fund. Names and addresses for who the checks are to be made payable to and the mailing addresses are included.

Description of the Crisis Situation: **(Please be specific and include as many relevant details as possible regarding this crisis, including why other means of funding are not available, and what the direct financial impact is on you.) Include any supporting documents (eviction notice, invoice, bill, domestic violence order, etc.).**

I agree to provide as much documentation as needed and/or requested to support this crisis financial need request in accordance with the provisions of the Maricopa Health Foundation Helping Hands Fund. I agree to keep my application and the decision of the chaplain confidential. I affirm that all information is accurate and complete.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

~~-----To be completed by fund administrator-----~~

**GRANT:**

Approved in amount of: \$\_\_\_\_\_ \_\_\_ Denied

Employee notified on \_\_\_\_\_, by \_\_\_\_\_

Date

Check requested on: \_\_\_\_\_ Check received on: \_\_\_\_\_

Date

Date

Employee notified on \_\_\_\_\_, by \_\_\_\_\_

Date