South Georgia Medical Center

Care Share Employee Assistance Fund- Application

SGMC is aware of the financial burdens that occasionally face our valued employees. Whether these challenges occur from natural disaster or personal problems, we care about you and want to help. Care Share was created to address the critical financial concerns of SGMC employees and is funded through employee donations. If you feel your situation fits these criteria, please fill out this confidential application.

For questions about the application process, please contact Human Resources.

Return completed application to: People Services *(Human Resources)*
Located on the 1st Floor of the Administrative Services Building
Attention to: Care Share Program Chair
Or Email completed application to: careshare@sgmc.org

Care Share Employee Criteria

1. The employee making the request for Care Share Funds must have completed their first year of employment.
2. The employee's request must be an acute emergency distress or financial difficulty.
3. The employee will be responsible for picking up any disbursed funds and delivering to the appropriate person or agency for payment.

Any information within this application will be kept confidential, disclosing only to those necessary to application processing.

Date:

Name:_____ Employee ID:_____

Employment Status: Full Time:_____ Part Time:_____

Home Address:_____

Mobile/Preferred Phone:_____

Please answer the following questions:

Have you been employed by South Georgia Medical Center for a year or more?_____

Are you Currently on a leave of absence?_____

Are you on a final warning of a disciplinary action status?_____

Do you have an unresolved Performance Improvement Plan?_____

Specific Amount Requested: $_____

Please describe your need. Be specific about how this became an emergency need for you, and what other solutions you have already tried. Include the date funds are needed. If applicable also include a copy of the bill in question. (Use additional sheets if necessary)

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If approved - If approved, the disbursement cannot be paid directly to you. The disbursement will be paid to the debtor (e.g. landlord, car repair shop, electric company, etc.).

Please complete the information for the debtor listed below.

Check payable to:_____ (Must be debtor information)

Address _____

City _____State_____Zip_____

Phone_____

Account # (if appropriate)_____

This is a confidential application. Distribution will be made directly to the appropriate provider and not to the applicant. The application will be reviewed by the Committee. In order to expedite your request, please provide copies of bills or proof of debt for which you are requesting relief.