**Request for Emergency Hardship Assistance**

***Shields Cares funds are available to permanent Shields Health employees experiencing financial hardship due to unforeseen circumstances. Employees may receive assistance from the Shields Cares fund only once during their employment tenure.***

**General Information** Date:

Employee’s Name: Family Member’s Name (if applicable): Relationship of Family Member to Employee: Home Address of Employee: Home/Cell Number: Employees Work Location:

Medical condition/emergency circumstance of employee or family member:

Effect condition/medical emergency has had on employee:

 **Financial Information**

Amount of relief requested: (Max amount $2,500.00)

Date by which relief is requested:

Please indicate how relief will be used:

Is any of the relief requested for payment of third party invoices or bills received? If so, please forward a copy of the invoices or bills. If you have any upcoming bills that you will be negligent on due to this medical hardship you can provide these as well.

Please forward any insurance denial letters, if applicable.

I understand the information provided in conjunction with this application will be used by Shields Cares to review my application. Any personal information provided about an adult family member is given with their knowledge and consent as indicated by their signature.

I certify by my signature that 1) that the information contained in this application is, to the best of my knowledge and belief, true, correct and complete; and 2) this application does not create or constitute any right to a distribution of funds or any other relief from Shields Cares.

Applicant Signature: Print Applicant Name: Signature of Family Member’s Name (if applicable): Print Family Member’s Name (if applicable):

Please return completed form to Alexandra Hardie at alexandrak@shields.com or call Alexandra at 857-755-0734.