

Date: _____

Broward Health Employees Emergency Relief Fund CONFIDENTIAL EMERGENCY ASSISTANCE PROGRAM APPLICATION

I. Applicant's Personal Data

Name: _____ Employee Number: _____

Marital Status: _____ Spouse Name: _____

Number of Dependents: _____ Total Number in Household: _____

Home Address: _____

Phone: _____ Email Address: _____

II. Detailed Description of Need (Required)

Use back of form if necessary. This section must be completed.



III. References for Verification of Need (At Least Two):

1. Name: _____ Telephone: _____
Address: _____ City/State/Zip Code: _____
Relationship: _____

2. Name: _____ Telephone: _____
Address: _____ City/State/Zip Code: _____
Relationship: _____

3. Name: _____ Telephone: _____
Address: _____ City/State/Zip Code: _____
Relationship: _____

Sections IV and V to be completed by Committee only

IV. Committee Recommendation: _____

V. Committee Member Signature(s): _____

Approved: Disapproved:

Broward Health Employees Emergency Relief Fund

FINANCIAL ANALYSIS CHECKLIST BASIC MAINTENANCE

I. Amount of Assistance Requested: \$ _____

II. Bill Description:

Amount Due: _____ Date Due: _____

Company Owed: _____

III. Bill Description

Amount Due: _____ Date Due: _____

Company Owed: _____

IV. Bill Description

Amount Due: _____ Date Due: _____

Company Owed: _____

V. Bill Description

Amount Due: _____ Date Due: _____

Company Owed: _____



VI. Transportation (Work Only; Monthly Gas/Car Payment): _____

VII. Monthly Food Expenses : _____

VIII. Monthly Child Care Expenses: _____

IX. Total Monthly Income (include any child support or alimony):

Sources: _____

Monthly Total: \$ _____

X. **Copy of Bills (Required)**

Please attach copies of your bills that support this application. This is required.

Rent/Mortgage

Cable/Internet/Phone

Gas/Electricity

Water

Insurance

Other

Signature of Eligible Employee (Required)

Date

Please return completed application to the Broward Health Foundation by mail, email or fax:

By U.S. Mail: 1201 South Andrews Ave., Fort Lauderdale, FL 33316

By Email: BHFoundation@BrowardHealth.org

By Fax: 954.712.4535



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