



Coastal Mississippi Employee Relief Fund Events Eligible for Assistance

Coastal Mississippi Healthcare Fund (CMHF), a charity affiliated with Singing River Health System (SRHS), supports SRHS' desire to assist employees with short-term financial assistance during unexpected and unavoidable financial hardships and emergencies. SRHS employees are eligible to apply for CMHF Employee Relief Funds under multiple circumstances. However, employees should use available resources such as insurance, disability coverage, savings, and local assistance programs before applying for assistance from CMHF.

The following guidelines, while not all inclusive, are provided to assist the employee, and supervisor, in determining if it is appropriate to request assistance from CMHF. The employee is responsible for completing the application and providing documentation of the need for assistance. An incomplete application will be returned to the employee for completion. **The employee is responsible for submitting documentation supporting their request for assistance.**

The application for assistance will be reviewed by the CMHF Executive Director, and, if required, the CMHF Board of Directors, as soon as possible. Once a decision has made for approval or disapproval, the employee will be informed as soon as possible.

Forward or fax the completed application to:

Daniel Shepherd
Executive Director
Coastal Mississippi Healthcare Fund, Inc
2012 Highway 90, Suite 34
Gautier, MS 39553
Phone: (228) 522-2184
Fax: (228) 522-2185

I. Home Catastrophe/Natural Disaster

- A. **Definition:** Employee's personal residence is destroyed or rendered unlivable by a natural disaster, including hurricanes, tornados, or fire. Emergency lodging expenses qualify for assistance as well.
- B. **Amount of Grant:** To be determined
- C. **Required Documentation:** Examples of documentation include proof of home ownership or rental agreement, photographs of damaged residence, insurance claim, police or fire report, lodging receipts, or repair estimates

II. Funeral/Emergency Travel Expenses

- A. **Definition:** Assistance is available to employees who have incurred the loss of an immediate family member* providing the employee can demonstrate significant financial difficulty paying for funeral expenses. An employee's spouse may apply for assistance in the event of an employee's death.

Additionally, employees may receive assistance for emergent travel expenses related to the death of an immediate family member.

- B. **Amount of Grant:** To be determined
- C. **Required Documentation:** Examples of required documentation include a statement from the funeral home indicating the employee is financial responsible for the cost of the funeral and a copy of the funeral expenses. A copy of bills, receipts, or credit card reports demonstrating the travel expenses of the employee.

III. Personal or Medical Emergency

- A. **Definition. :** Assistance may be available for employees who have encountered financial hardships for reasons beyond their control, such as a medical emergency.
- B. **Amount of Grant:** To be determined
- C. **Required Documentation:** Copies of utility bills, medical bills, pharmacy receipts, automobile repair estimates, etc

IV Expenses that will not be considered:

Expenses that will not normally be considered for assistance include; credit card debt, discretionary or elective bills (cable television), car payments, monthly mortgage, child support, attorney fees, garnishments of an employee's paycheck for any reason, or past due monthly bills.

* Immediate family is defined as: Spouse, brother/sister, children, step-children, parents, grandparents, and in-laws.



**COASTAL MISSISSIPPI
HEALTHCARE FUND, INC**
A Charity Affiliated with Singing River Hospital System

Application for Assistance

Employee Name:	Amount Requested:
Employee Date of Birth:	Employee SSN:
Employee Address:	Other assistance (Red Cross, United Way, family, etc.):
Employee Phone: Work _____ Home _____ Cell _____	Employee Dept: _____ Facility: _____ Length of Emp. ____ years ____ mos Supervisor: _____ Supervisor's Phone: _____
Income (per pay period): Employee _____ before deductions _____ after deductions Spouse Salary _____ before deductions _____ after deductions per hour per week per month	Other income (Social Security, VA, Workman's Comp, Retirement, etc.) Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____ Source: _____ Amount _____
Dependents: Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____ Name _____ Age _____	Banking information: Checking balance _____ Bank _____ Savings balance _____ Bank _____ Other balance _____ Source _____ Other balance _____ Source _____ Other balance _____ Source _____
Housing Expenses: <input type="checkbox"/> Own Monthly payment \$ _____ Mortgage balance \$ _____ <input type="checkbox"/> Rent Monthly payment \$ _____	Additional Monthly Obligations: Utilities \$ _____ Food \$ _____ Clothing \$ _____ Misc \$ _____
Creditors: Name Monthly payment Balance _____ _____ _____ _____	Please check the type of assistance required: <input type="checkbox"/> Home Catastrophe/Natural Disaster <input type="checkbox"/> Funeral Expense/Emergency Travel Expense <input type="checkbox"/> Personal or Medical Emergency

Describe your emergency and specific needs, in detail. Please attach supporting documentation.

I hereby certify, to the best of my knowledge and belief, the above information to be true and correct and give my permission for the Coastal Mississippi Healthcare Fund, Inc. to verify this information. I understand any intentional false statements will be considered an attempt to commit fraud upon the Coastal Mississippi Healthcare Fund, Inc. and may result in denial of my request for assistance. Additionally, I authorize Coastal Mississippi Healthcare Fund to disclose any confidential and/or financial information to the Coastal Mississippi Healthcare Fund Board of Directors as it pertains to the above emergency. I further authorize Coastal Mississippi Healthcare Fund and the SRHS Human Resource Department to disclose any confidential and/or financial information to other community agencies (i. e., Red Cross, United Way) to determine if I am eligible to receive assistance from such agency.

Signature of applicant: _____ Date: _____

Signature of supervisor: _____ Date: _____

FOR CMHF USE ONLY

DATE APPROVED	DATE DISAPPROVED
COMMENTS	
SIGNATURE	