PATTI GUILIANI SPECIAL FUND APPLICATION
Guidelines

CRITERIA: The following guidelines are considered in evaluating each application:

- Request must be for an emergent need. **Awards must be picked up within 3 business days or the funds will be returned to the account and it will be assumed that the request has been withdrawn.**

- Applicant must have an ongoing relationship with, or receive services from, St. Joseph's Medical Center or St. Joseph's Behavioral Health Center either as an employee, employee's immediate family member/legal dependent/significant other living in the employee's home, or is a patient or volunteer.

- All other financial resources must be unavailable or exhausted. Consider other options for helping the applicant such as family, friends, co-workers, local church/community, employee donations, credit union/bank loan, etc. Patti Guiliani Special Fund monies should be spent as a last resort.

- There is a one-time assistance limit. Previous Patti Guiliani Special Fund recipients are not eligible for assistance.

- Examples of areas of assistance would include food, shelter, medical equipment, and medical services. Strong preference will be given to applications that are directly related to health issues.

- Patti Guiliani funds cannot be used for airfare, credit card payments, or DMV renewal fees. Requests for rent or utilities must be related to a medical need. Rent/Mortgage payments are limited to a one-time maximum of $500.

- Requests for assistance with burial expenses are limited to the plot liner and opening and closing costs, with a maximum of $500.^{00} per application. The Patti Guiliani Special Fund Chair will deal directly with the cemetery, not the funeral home, when making payment arrangements.

- Requests for assistance with cremation expenses are limited to $500.^{00} per application.

- Each application/request is limited to $1,000.

APPLICATION PROCESS

- All requests for assistance must be sponsored by a SPIRIT Club member. Members of the general public cannot apply directly for assistance. An applicant may not sponsor him/herself. The sponsor, **NOT** the applicant, must complete the application form.

- The completed application form is submitted to the Special Patti Guiliani Fund Chair or the Fund Development Department or a SPIRIT Club Steering Committee Member. Incomplete forms will be returned to the sponsor prior to consideration.

- The Patti Guiliani Special Fund Chair will review the application and contact the Sponsor or Applicant for clarification if necessary. The Chair summarizes and submits the request to the Committee for vote via e-mail. The majority of the responses must support the application for the request to be granted.

- The Patti Guiliani Special Fund Chair may approve an application independently if the request is under $100.

- All monies are paid to the provider of service rather than directly to the applicant. Examples of areas of assistance would be, but are not limited to: medical equipment, pharmaceuticals, food, transportation, utilities, shelter and burial expenses.

- Information regarding the service or agency to be paid, and the specific amount to be paid, must be requested at the time the application is submitted. Attach the invoice, bill, or other verification to the request form.

Application # _____

PATTI GUILIANI SPECIAL FUND
APPLICATION FORM

This application must be completed by the sponsor, NOT the applicant. Incomplete applications will be returned. Please submit the completed application to Dawn Bacon, Chairperson, Patti Guiliani Special Fund, in the Employee Health Department at St. Joseph's Medical Center.

DATE: _____ SPONSOR: _____ DAYTIME PHONE #: _____

1. APPLICANT'S NAME: _____ AGE: _____

   ADDRESS: _____

   HOME PHONE: _____ MALE ___ FEMALE ___

2. IS APPLICANT EMPLOYED: YES__ NO__ IF YES, WHERE? _____

   CURRENT SALARY: _____

3. HOW LONG HAS APPLICANT BEEN EMPLOYED? _____ IF NOT CURRENTLY EMPLOYED, STATE REASON: _____

   _____

4. NUMBER OF DEPENDENTS: _____ AGES: _____

5. DOES APPLICANT LIVE WITH OTHERS? YES ___ NO ___ IF YES, LIST ALL PERSONS WITH WHOM APPLICANT LIVES AND THEIR AGES: _____

   _____

6. IS THERE ADDITONAL INCOME TO THE HOUSEHOLD (i.e. child support, spouse support, disability, unemployment, etc.)? YES ___ NO ___ IF YES, LIST TYPE OF INCOME AND AMOUNT: _____

7. DOES ANY FAMILY MEMBER HAVE HEALTH OR HOSPITALIZATION INSURANCE (include insurance paid by an employer or absent parent)? YES ___ NO ___ IF YES, PLEASE LIST: _____

8. DOES ANY FAMILY MEMBER HAVE AN ILLNESS OR DISABILITY WHICH MAKES IT DIFFICULT TO WORK OR TAKE CARE OF THEIR NEEDS? YES __ NO __ IF YES, WHICH FAMILY MEMBER? _____ TYPE OF PROBLEM? _____

   _____

   _____

9. HAS A HEALTH PROBLEM OR CATASTROPHIC SITUATION CREATED THIS NEED?

YES __ NO __ If yes, please describe: _____

_____

_____

_____

10. WHAT OTHER RESOURCES HAVE YOU PURSUED (i.e. vacation pay, credit union, other family members, payment plan for debts)? _____

_____

_____

_____

11. DESCRIBE APPLICANT'S SPECIFIC NEED OR REQUEST (include any information which you feel might be helpful to the Committee). _____

_____

_____

_____

_____

12. WHAT IS THE APPLICANT'S PLAN TO REMEDY HIS/HER FINANCIAL CRISIS GOING FORWARD? _____

_____

13. WHAT IS THE RELATIONSHIP BETWEEN THE APPLICANT AND ST. JOSEPH'S?

__ Patient __ Patient's Family Member __ Employee __ Other – Please Explain: _____

_____

14. AMOUNT REQUESTED AND PROVIDER OF SERVICE(S)? _____

_____

_____

DO NOT WRITE BELOW THIS LINE – FOR COMMITTEE USE ONLY

Approved / Denied