Heartland Dental Foundation Economic Hardship Program Application

Questions or Concerns?
Contact: Heartland Dental Hardship Program Relationship Manager
hardship@enrichingourcommunity.org - 217-253-8939 call or text

PURPOSE: Help Heartland Dental supported dentists, team members and support professionals who are experiencing economic hardship and are unable to afford housing, utilities, and other basic living needs because of a **qualified disaster, life-threatening illness or injury, death or other catastrophic or extreme circumstances** beyond the employee's control.

ELIGIBILITY: All Heartland Dental employees, supported dentists and support professionals who are employed part-time or full-time for at least six (6) months prior to submitting this application AND have experienced a qualifying incident (see Section A for definitions) within 60 days of the date of application. In the case of death of the employee, then spouse or eligible dependents may apply. **An employee can only be approved for assistance once within a twelve-month period.**

GRANTS: The maximum grant amount available for assistance is $5,000 for an employee death incident and $2,500 for all other incidents; however, grant amounts vary based upon the nature of the qualifying incident and related expenses. Awards from the fund are intended to assist the recipient employee through the crisis; they are not intended to make the employee whole. All payments are made directly to vendors as bill payments; assistance funds are not sent directly to applicants.

SECTION A: WILL YOU QUALIFY?

To qualify for this program and receive assistance you must meet certain requirements:

1) You must meet employment eligibility requirements as outlined above.
2) You must be experiencing financial hardship that affects your ability to pay for basic living needs.
3) The qualifying incident (see categories below) must have happened within the past 60 days.

☐ **Natural Disaster:** For situations, such as a wildfire, flood, tornado, hurricane, severe storms or earthquake, that have damaged or destroyed the employee's primary residence or have required the employee to evacuate their primary residence. The Fund cannot pay to repair other property and cannot pay to replace non-essential items, such as electronics or furnishings. *Photographs or insurance reports may be required.*

☐ **Life-Threatening or Sudden, Unexpected Serious Illness Or Injury:** For the employee, spouse or domestic partner and eligible dependent(s). The Fund is not a substitute for medical insurance and is not intended to cover insurance deductibles. Employees do not automatically qualify for a grant when they, or their dependents, are diagnosed with or suffer a life-threatening or serious illness or injury. There must be resulting financial need including an inability to pay basic living expenses. **IRS tax documentation may be required to verify dependent status**. *Doctor confirmation or medical documentation will be required.*

☐ **Death**: This includes the death of the employee, spouse, domestic partner or eligible dependent(s). The loss of income, cost of burial or funeral expenses, or resulting medical bills prevents an employee or the employee's family from affording basic living expenses. IRS tax documentation may be required to verify dependent status. *Copy of the death certificate or obituary will be required.*

☐ **Catastrophic or Extreme Circumstances:** This includes but is not limited to: fire, major home damage that could not be prevented, serious crime against the employee (robbery, arson, assault, domestic abuse, extreme vandalism), or another *reportable* incident beyond the employee's control that impacts the ability to afford basic needs. Catastrophic or extreme circumstances do **not** include: credit card debt, home foreclosure, wage garnishment, bankruptcy, child support payment, car repair, taxes, or accumulated financial distress. *Police, Fire or other official incident report may be required.*

SECTION B: INFORMATION ABOUT YOU

Employee Name (please print clearly) _____

Permanent Address _____

City _____ State _____ Zip _____ County/Parish _____

Daytime Phone _____ Other Phone _____

Email Address _____

If you can not receive mail at your permanent home address due to the qualifying incident, please provide another mailing address:

Temporary Address _____

City _____ State _____ Zip _____

**Approval Notification will be sent to you by mail and email, so please provide a valid mailing and email address.

Have you applied for this program before? ☐ Yes ☐ No If YES, date applied _____

Employee Name (please print clearly) _____

SECTION B CONTINUED: INFORMATION ABOUT YOU

Marital Status ☐ Single ☐ Married ☐ Divorced/Separated

Family Members (Spouse/Dependents Only)	Relationship	Age

What supported location do you work in? _____ City _____ State _____

Job Title _____ Supervisor _____

Date of Hire _____

SECTION C: PERSONAL FINANCIAL STATEMENT

Required: ***Please attach copies of most recent pay stubs for each wage earner.***

YOUR ASSETS

Cash (in hand or checking)	$
Savings Account Balance	$
Other accessible cash or investments (excluding IRA, 401K or other retirement assets)	$
Real Estate	$
Vehicles (car, boats, RVs)	$
Total Assets	$

YOUR MONTHLY LIVING EXPENSES

Rent or Mortgage	$
Utilities	$
Food	$
Medical Expenses	$
Car Loans	$
Gas/Incidentals	$
Other	$
Total Monthly Expenses	$

YOUR ***MONTHLY*** HOUSEHOLD INCOME

Your average **monthly net** (after deductions)	$
Spouse/Partner's average **monthly net** income (after deductions)	$
Child Support Income **per month** (self and/or spouse/partner)	$
Social Security/Pension income **per month** (self and/or spouse/	$
Disability income **per month** (self or spouse/partner)	$
Unemployment income **per month** (spouse/partner)	$
Other income received **monthly** (please list):	$
Total Monthly Income	$

Additional documentation of income or expenses may be required to complete the application. You will be notified by email and phone if such information is needed.

Employee Name (please print clearly) _____

SECTION D: DESCRIBE YOUR SITUATION

Which qualifying situation caused the financial hardship? (Read the descriptions on page 1 in Section A. Circle the category below that best fits your situation. Call/text 217-253-8939 with questions.)

Natural Disaster **Life-Threatening Illness or Injury** **Death** **Catastrophic or Extreme Circumstances**

Name of Incident: _____ Date of Disaster _____
(example: tornado, fire, type of injury, name of illness, domestic abuse) ***(must be within past 60 days)***

Is the affected person covered by medical or disability insurance? _____ Have they applied for disability? _____

If your home was damaged, will insurance cover part of the cost? _____ Your deductible amount? _____

Describe the incident in detail. What happened? _____

_____

_____

_____

_____

_____

SECTION E: APPROVAL

The Heartland Dental Foundation Economic Hardship Program Manager will review your application and determine if you are approved, denied or if more information is needed to make a decision. If approved for assistance, a Vendor Payment Request Form will be sent to you via email and text (as provided on page 1 of this application). The Vendor Payment Request Form will include instructions on submitting copies of bills and supporting documentation for payments.

SECTION F: DECLARATIONS AND AGREEMENT

No employee is entitled to receive a grant, either by their employment, their history of contributions to the Fund or because of any precedent inferred from a previous grant from the Fund. Grants will not be made before an employee has demonstrated an immediate financial need and provided all required documentation.

This application will be treated in a confidential manner by Southeastern Illinois Community Foundation; however non-identifying statistical information will be reported to Heartland Dental on a periodic basis.

Employees are expected to provide truthful and accurate information. In its due diligence, if the Foundation discovers any information to be untrue, it shall have the right to unilaterally waive its confidentiality and report its findings to Heartland Dental. The fiduciary expectations of all Heartland Dental employees are paramount and a breach of these standards will be reported to Heartland Dental.

Your signature below certifies that the information provided is true and complete, authorizes Heartland Dental Foundation Economic Hardship Fund, administered by Southeastern Illinois Community Foundation, to obtain and/or verify all information necessary to process this application, and releases Heartland Dental and Southeastern Illinois Community Foundation from any liability associated with the rejection of or funding of this application. In addition, you agree to provide the requested documentation supporting the information provided.

Applicant's Signature _____ Date _____

Mail, fax or scan/email completed and signed application with requested documentation to:

Heartland Dental Economic Hardship Fund
PO Box 1211, Effingham, IL 62401
Phone/Text: 217-253-8939
Fax: 217-342-4995
hardship@enrichingourcommunity.org