

# Heartland Dental Foundation Economic Hardship Program

## APPLICATION FOR ASSISTANCE

**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 **\$2,500**; 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. *For assistance in completing an application or grant documentation required, please call 217-342-4988 or contact Maggie at [maggie@enrichingourcommunity.org](mailto:maggie@enrichingourcommunity.org).*

## 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. 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 Incident:** 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)	\$
<b>Total Assets</b>	\$

**YOUR MONTHLY LIVING EXPENSES**

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

**YOUR MONTHLY HOUSEHOLD INCOME**

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

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 217-342-4988 with questions.)

**Natural Disaster    Life-Threatening Illness or Injury    Death Incident    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? \_\_\_\_\_

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Describe how the incident has caused your financial hardship. How has this made it hard to afford basic living expenses?

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Estimate the financial impact of the incident. How much has this cost you? \_\_\_\_\_

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Please tell us anything else that would help us better understand the hardship you and/or your family are experiencing. If this application is being submitted by someone other than the employee (in the case of death or other inability to complete the form), please explain and provide a contact name and information.

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Employee Name (please print clearly) \_\_\_\_\_

## SECTION E: ASSISTANCE GRANTS

**Grants are paid to vendors in response to an unpaid bill or invoice for eligible, basic expenses. Examples of eligible expenses:** See *Grant Documentation* for more detail.

- Rent, mortgage or other housing payments
- Temporary housing and security deposits for new housing
- Essential utility bills (electricity, heat, water, etc.)
- Medical expenses (bills) incurred within the last 60 days related to the incident, not eligible for reimbursement, covered by insurance or part of insurance deductible
- Home repairs necessary to restore or maintain home safety
- Essential appliances and furnishings
- Funeral expenses
- Car payments, repairs or car insurance

**Grants cannot be made to pay for other, non-essential expenses such as:**

- Reimbursements to employee or other individuals
- Accidental damages due to negligence
- Accumulated financial issues or credit card debt
- Legal fees, legal fines or court costs

**Grant Payment:** If the application is approved, payment(s) to the vendor(s) will be made by check and will include the employee's account number, if applicable, and a copy of the bill or invoice provided with the application. The applicant will be notified of the payment(s) by mail and email.

**Vendor(s):** Please list the bills you need assistance with, ***listing the most important ones first***. If you are requesting payments to more than three vendors, attach a page with identical information provided. In addition to listing vendors, please attach an invoice, bill, or statement directly from each vendor.

Vendor/Biller Name	
Complete Mailing Address for Payment	
Basic Need Covered	
Payment & Due Date	
Account Number or Identifying Information	

Vendor/Biller Name	
Complete Mailing Address for Payment	
Basic Need Covered	
Payment & Due Date	
Account Number or Identifying Information	

Vendor/Biller Name	
Complete Mailing Address for Payment	
Basic Need Covered	
Payment & Due Date	
Account Number or Identifying Information	

Employee Name (please print clearly) \_\_\_\_\_

## SECTION F: GRANT DOCUMENTATIONS

Each application for a grant must include:

- ◆ Assistance Application
- ◆ Vendor documentation (bills to be paid, invoices, etc.)
- ◆ A copy of the death certificate or obituary notice, if a death is involved
- ◆ Report from fire, police, or insurance; insurance claim; photograph of damaged residence, etc.
- ◆ Medical documentation, if needed
- ◆ Copy of paystub or payment statement

For those asking for **home repairs**, please send: home ownership document (mortgage bill, home owners or flood insurance claim or policy with applicant's name and address listed, or copy of online deed record from county real estate assessment website); repair estimate on company letterhead; insurance correspondence

For those asking for help with **deposits/rent at new dwellings**: landlord/leasing office correspondence showing move-in costs; insurance correspondence

For those asking for help with **normal monthly bills**, please send: receipts from your qualifying incident expenses (hotel, building supplies, generator, etc.) and basic household bills (copy of actual bill) you can not pay on your own (rent/mortgage, water, gas, electric, etc.)

*For assistance in completing an application or grant documentation required, please call 217-342-4988 or [maggie@enrichingourcommunity.org](mailto:maggie@enrichingourcommunity.org).*

## SECTION G: 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**  
**2701 South Banker, Suite 102A, Effingham, IL 62401**  
**Phone: 217-342-4988**  
**Fax: 217-342-4995**  
**[maggie@enrichingourcommunity.org](mailto:maggie@enrichingourcommunity.org)**