Compassion Fund Application

The Compassion Fund, Inc. is a non-profit 501(c) (3) charitable organization established in 2009 for the purpose of providing emergency relief assistance to the SHC Family. The SHC Family consists of stakeholders, residents and their immediate families and members of the communities surrounding Signature HealthCARE facilities. The mission of the Compassion Fund is to be a follow-up responder in serious situations caused by **unforeseeable and uncontrollable hardships**. **The fund is not intended for long-term or recurring financial support.**

Reviewers will consider your situation based first upon the criteria listed on page 3 while at the same time taking into account your financial history and current situation. Failure to provide the full documentation or to adequately explain how your financial need effectively relates to the criteria on page 3 can seriously limit your application's favorable review. All information provided for review must be current and accurate.

All applications require an Advocate, which is someone to assist you in the application process and to act as a point of contact during the process. Advocates usually are SHC Chaplains or Human Resource Directors as they have been trained on how to assist in the process, although other SHC Employees with company email addresses are permitted to serve in this capacity if needed. Advocates are to maintain confidentiality of your case before, during and after the review of your application.

Your Advocate is the sole person authorized to send information to the Compassion Fund facilitators or to receive communications from them regarding your case.

Please fill out the following application **COMPLETELY,** providing all requested documentation. If handwritten, please print legibly and always retain a copy for your records. **Incomplete applications will NOT be sent to the Selection Committee** and will be sent back to the Advocate with an explanation as to what information is still needed.

Have your Advocate email, fax, or mail your completed application to the Compassion Fund at the contact information provided at the bottom of the page.

PLEASE NOTE: This first page is for information only and should NOT be included with your application.

The Compassion Fund, Inc. 12201 Bluegrass Pkwy, Louisville, KY 40299
Phone: (502) 568-7800 • Fax: (502)568-7166 • E-mail: cfund@thecompassionfund.org
www.thecompassionfund.org

APPLICANT INFORMATION

Applicant Name _____ Social Security Number **(REQUIRED)** _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Telephone Number _____

Advocate Information

All Applications must have an Advocate to assist in the process and be the point of contact for the Applicant. Usually the Advocate will be the Chaplain or Human Resources Director.

Name of Advocate _____ Title _____

Email Address _____ Telephone Number _____

Facility Information

Please identify with which Signature HealthCARE Facility/Community the Applicant is associated.

SHC Facility's Name _____ City _____ State _____

Please explain how the Applicant is related to the Facility:

_____

If Applicant is a current SHC Stakeholder:

Has Applicant exhausted PTO? ☐Yes ☐No

Has Applicant received any PTO donations? ☐Yes ☐No

If Yes, How many hours? _____

COMPASSION FUND CRITERIA

Please check the appropriate TRIGGERING EVENT(S) that applies to your situation:

Fire ☐ Flood ☐ Storm ☐ Crime ☐ Illness ☐ Injury ☐ Accident ☐ Death ☐ Other ☐

If the situation is 'Other' please describe:

The Compassion Fund is available to cover only those expenses which are essential to life (called 'Eligible Items'). These items **may** include:

- Housing Costs;
- Utilities (heat/air, water, sewer, electric, sanitation);
- Some transportation or relocation costs.

In cases of a death for immediate family ONLY* the Compassion Fund **may** cover:

- Funeral costs, capped at $900, and paid directly to the Funeral Services provider to be applied towards any unpaid portion of the bill;
- Some transportation costs related to the death;
- Awards will NOT be made if: (1) payment for services has been already made, (2) if there is any life insurance whatsoever for the deceased or (3) if there are appropriate benefits offered through health plan policies, group benefits or assistance plans which are available to the applicant.

In cases of accident, illness or injury for immediate family ONLY*, the Compassion Fund **may** cover:

- Medical travel and lodging;
- Mandatory-to-treatment, medically prescribed medications which are not covered by insurance or other means of provision;
- Medical insurance premium costs or co-pay costs.

The Compassion Fund Selection Committee reserves the right to determine what is and is not to be considered as "eligible" for any case. Essential-to-life items which cannot be specifically documented such as groceries, over-the counter medications or home fuel may be funded at the sole discretion of the Selection Committee.

The Compassion Fund **generally does not** fund items such as medical or hospital bills for services already rendered as these can usually be negotiated and long term payment plans set up.

The Compassion fund **does not** fund requests for payment of items such as phone bills, car payments, home or auto insurance payments, cable or internet service, legal bills, loan or credit card payments, bank or check cashing fees, child support or any other items deemed **not-essential to life**.

*Immediate family is defined as spouses, parents, children, grandparents, in-laws or siblings of the applicant.

CIRCUMSTANCES OF HARDSHIP

Please describe the circumstances which you believe demonstrate eligibility for relief assistance. Please describe fully the **TRIGGERING EVENT** of your situation, especially as related to the criteria described on page 3. Please use additional sheets if necessary and attach any and all supporting documentation.

What else has been done up to this point to address this need? (i.e. sought assistance from other entities (specify where), asked for assistance from relatives, called creditors to arrange alternative payments, etc.)

How will an Award be used to address this need?

DETAILS OF HELP REQUESTED

Please completely fill in the grid below with information on each specific item where you are requesting assistance. All items should be listed for which help is being requested and a copy of all corresponding backup for each item should be attached. Feel Free to expand on additional pieces of paper if needed.

	Name and/or Type of Help Requested	Explanation of Help Requested	Bill or Estimate Attached?	Amount of Requested Help
1				
2				
3				
4				
5				
6				
7				
8				
		TOTAL AMOUNT OF ASSISTANCE REQUESTED:		

Further Information/ Explanation Concerning the Above Requested Help:

DOCUMENTATION

Please enclose **ALL** of the following requested items and check below those that are being provided as attachments to this application. If there is a compelling reason that a requested item cannot be provided, please indicate such in the appropriate space.

FAILURE TO PROVIDE THE REQUESTED DOCUMENTATION, EVEN FOR A STATED REASON, MAY RESULT IN A DELAY OF PROCESSING OR A DENIAL OF AWARD.

REQUIRED ATTACHMENTS - (Please indicate below those attached)

A copy of bills or invoices for EVERY ITEM for which funding is being requested:

☐ Attached ☐ Not Attached
If not attached, please explain why:
_____

Two most recent pay stubs:

☐ Attached ☐ Not Attached
If not attached, please explain why:
_____

Two months of bank statements on all household accounts:

☐ Attached ☐ Not Attached
If not attached, please explain why:
_____

If a result of a crime, fire, flood or natural disaster, a Police or Fire Dept report, Examiner report, Insurance Claim Report, photographs or other similar items:

☐ Attached ☐ Not Attached ☐ Not Applicable
If applicable but not attached, please explain why:
_____

If involving a death, invoice on letterhead for services from funeral home or providing vendor including name of deceased, and the name, address and phone number for the person responsible for the bill which must be either the Applicant or someone from the Applicant's immediate family.

☐ Attached ☐ Not Attached
If not attached, please explain why:
_____

ADVOCATE TESTIMONY

Advocates (or other references the Applicant may wish to provide) should provide a brief explanation of why they believe the Applicant be considered for an award of funds as well as any other information they consider pertinent to the request.

If the person referring the applicant is someone other than the Advocate, please provide their names and contact information along with the recommendation.

Feel free to attach testimonies on additional sheets of paper if needed.

REQUIRED SIGNATURES

I, the undersigned, have examined this application for assistance and certify the claim to be valid and that all the answers and information are all true and correct and that the request for emergency assistance is necessary and the Applicant has exhausted all other resources available for assistance:

Signature of Applicant:

_____ Date: _____

Signature of Advocate:

_____ **Date:** _____

The Compassion Fund reserves the right to limit award amounts as necessary in order to be good stewards of our limited funds so as to be able to assist as many applicants as possible.

Applicants who are now (or who once were) Signature Stakeholders must be considered employees in good standing (either now or at the time when they left) in order to be eligible for assistance from the Compassion Fund. This requirement also applies to immediate family members of current or former stakeholders as well.

PLEASE NOTE: All information provided must be current and accurate.

Fraudulent applications will result in denial of your application and may result in administrative action and/ or legal action as well.

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