ARCHWAY EMPLOYEE CRISIS PROGRAM (AECP)

Criteria for Funding and Application

The Archway Employee Crisis Program provides short-term, emergency support to employees that are experiencing a non-recurring financial hardship resulting from a sudden, severe, overwhelming and unexpected event that is beyond their control.

The Archway Programs' Employee Crisis Program Committee administers the Archway Programs' Employee Crisis Program and in its sole discretion determines incident eligibility and award amount up to $500*. Archway Programs' HR staff is available to assist all applicants in this process. Call 856.767.5757, extension 221 with questions.

Eligibility

Those eligible for consideration of a grant from the Employee Crisis fund are:

- Archway Programs' active, regular full-time or part-time employees who have completed one (1) year of continuous service.
- Have a temporary financial hardship due to an emergency life situation (See Request Criteria Section).
- An employee can apply for each incident only once even if it is on-going.

Grants

*****The maximum grant amount available for assistance is $500 per associate/household, once in any 12 month period and a maximum amount of three (3) times during employment lifetime. The maximum award is not guaranteed, and in some cases, a lesser amount will be awarded. All payments are made directly to vendors as bill payments; assistance funds are not sent directly to applicants.

Request Criteria

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

1. You must meet Archway Programs' Employee Crisis Program employment requirements outlined above.

2. You must be experiencing financial hardship due to the unexpected nature of this qualifying incident.
3. The qualifying incident must have happened within the past 90 days.
4. Your situation MUST fall into one of the following six categories –
    a. **Natural Disaster**: 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, e.g. electronics, etc., photographs and/or insurance reports may be required.
    b. **Catastrophic Illness or Injury**: The Fund is not a substitute for medical insurance; employees do not automatically qualify for a grant when they are diagnosed with or suffer a life-threatening or serious illness or injury. There must be resulting financial need placing significant pressure on the family's financial resources. Doctor confirmation and/or medical documentation will be required.
    c. **Death Incident**: This includes the death of the employee, spouse, or eligible dependent(s), as defined in the Archway Program's Employee Handbook. The loss of income or the cost of funeral expenses or medical bills must significantly impact the family's resources. The Fund may also be able to pay expenses to bring a child whose parents have died to live with a new family, typically a relative. The Fund cannot pay for travel to funerals, caskets, grave markers or other funeral expenses.
    d. **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 or another reportable crime) that significantly impacts the family's resources. Police, fire, or other official incident report may be required.
    e. **Military Deployment:** Employees affected by deployment of a spouse, causing hardship on household family.
    f. **Federal/State Government Shutdown**: Employees affected by government shutdown, which has exceeded 30 days.

Assistance grants do not include reduced work hours or pay (lost compensation due to missed time from work); expenses associated with divorce settlements or child custody cases; items covered by insurance, insurance co-pays, premium or deductibles; credit card bills; home foreclosure; car repair; accumulated financial distress; accidental damages due to negligence; legal fees.

AECP APPLICATION FOR ASSISTANCE

General Information

Name: _____
(First) *(Last)*

Permanent (Primary) Address

Street: _____

City, State, ZIP: _____

County: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Preferred Email: _____

Department: _____

Work Site: _____

Marital Status *(please check one)*:

____ Single ____ Married ____ Divorced/Separated ____ Domestic Partner

If, because of the catastrophe, you cannot receive mail at your home, provide current address and/or alternate mailing address from above. Approval notification is sent to you by mail, so please provide a valid mailing address.

Street: _____

City, State, ZIP: _____

Employee Name: _____

Family Members ***(Spouse and Dependents ONLY)***	**Relationship**	**Age**

Rent or own? (*Please circle one.)* Rent Own

Number of Adults in Household: _____ Number of Children in Household: _____

Which qualifying situation caused the financial hardship? *Please check the category below that best fits your situation.*

_____ Natural Disaster

_____ Catastrophic Illness or Injury (*Please refer to 'Attachment A' on page 8 of the application.)*

_____ Death Incident

_____ Catastrophic or Extreme Circumstances

_____ Military Deployment

_____ Government Shutdown

Name of Incident: _____
(i.e., tornado, fire, flood, type of injury, name of illness)

Date of Incident (*MUST BE WITHIN PAST 90 DAYS*):_____
(mm/dd/yy)

Amount Requested: $_____

Have you previously applied to the Archway Programs' Employee Crisis Program for assistance?
(Please circle) Y N

If yes, provide the date the application was submitted: _____
(mm/dd/yy)

If your primary home was damaged, will insurance cover part of the cost? *(Please circle)* Y N

Important to Note: ***If application is for a Catastrophic Illness or Injury, doctor confirmation and/or medical documentation will be required. Please see 'Attachment A' on page 8.***

If applying for Catastrophic Illness/Injury, please provide the Healthcare Provider's, name, address, and telephone number in the provided space below.

Last Name: _____

First Name: _____

Street: _____

City, State, ZIP: _____

Telephone Number: _____

If the application is approved, the AECP will make the grant(s) in the form of a check(s) payable to the vendor(s) and the employee will be notified of the payment(s) by mail.

All grants are made directly to vendors as bill payments. Assistance funds are not sent directly to applicants. Please provide the name of the vendor, the complete address, the account numbers *(when relevant),* amount due, and due date. Please attach appropriate documentation *(i.e., bills, lease, mortgage coupon, statement, etc.).*

Vendor Name: _____

Vendor Address: _____

Basic Need Covered: _____

Payment Amount and Due Date: _____

Account Number: _____

A completed application must be submitted in order for the application to be reviewed. Incomplete applications will be held for 30 days after the application has been submitted awaiting the additional information required. After 30 days, the applicant will need to apply by resubmitting a new application and all supporting documents again. AECP cannot make payments without clear, complete information including full account numbers and all documentation. Omitting copies of your bills will delay your application.

AECP Checklist:

- Carefully read the requirements to see if you qualify.
- Signed Declarations and Agreement page
- Supporting documents are necessary for evaluating and determining the eligibility of the grant request.
- Examples include but are not limited to:
  - Vendor documentation *(bills to be paid)*
  - Mortgage Coupon or Statement/Lease
  - Lodging Receipts in the case of evacuation
  - Insurance Claim Forms
  - Medical Documentation if needed *(See Attachment A)* and Explanation of Benefits (EOB)
  - Police, Fire, or other official incident report if for Catastrophic Circumstances
- If death incident, please provide a copy of the Death Certificate or Obituary

AECP Agreement and Authorization

PLEASE READ CAREFULLY

No employee is entitled to receive a grant, either by their employment, their history of contributions to the AECP or because of any precedent inferred from a previous grant from the AECP. 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 the Archway Employee Crisis Program Committee, however; non-identifying statistical information will be reported to Archway Programs on a periodic basis.

By signing below, I certify that the information provided in this grant application and any attachments to it is true and correct as of the date set forth below. My signature acknowledges and permits the Archway Employee Crisis Program Committee to verify all information including employment status. This includes making appropriate contacts and disclosures with my creditors, health care provider and others referenced in this application to ensure that reported information is accurate.

Signature Required: _____ Date: _____

Application Status: _____ Approved _____ Denied _____ Withdrew _____

Log #:_____

Please return the completed and signed application with requested documentation to:

Archway Programs
C/O Human Resources (Denise Milazzo)
Attention: Archway Programs Employee Crisis Program
P.O. Box 668
Atco, NJ 08004-1645
Phone: 856.767.5757
Email: denise.milazzo@archwayprograms.org

ATTACHMENT A

TO BE COMPLETED BY HEALTH CARE PROVIDER
IF APPLYING FOR CATASTROPHIC ILLNESS OR INJURY

To the attending physician: *The employee below has applied for crisis funding from the Archway Programs' Employee Crisis Program for his/her self and/or the patient named below. This form is required for your patient to be considered for a grant.*

Name of Archway Employee: _____

Name of Patient:_____

Patient Relationship to Employee:_____

Patient Address:_____

City, State, ZIP:_____

Does the patient have a catastrophic illness or injury? *Please circle.* Y N

Note: Catastrophic illness or injury is defined as a serious illness, serious injury, impairment, or physical condition that a licensed physician certifies as critical, life threatening or terminal.

Date of which the patient's catastrophic illness/injury commenced: _____
(mm/dd/yy)

Probable duration of patient's catastrophic illness or injury: _____

Describe the catastrophic illness or injury using appropriate medical facts within your knowledge *(attach supplemental sheets if necessary)*:

_____

_____

_____

_____

Does the patient need constant care? *Please circle.* Y N

If yes, what is the estimated amount of time that the patient will need this care?

_____

_____

_____

Name and Address of Healthcare Provider:

_____

_____

_____

Telephone Number of Healthcare Provider: _____

Signature of Healthcare Provider:_____

Date:_____

Please return the completed and signed application with requested documentation to:

Archway Programs
C/O Human Resources (Denise Milazzo)
Attention: Archway Programs Employee Crisis Program
P.O. Box 668
Atco, NJ 08004-1645
Phone: 856.767.5757
Email: denise.milazzo@archwayprograms.org

Archway Programs' Employee Crisis Program

1. I authorize Archway Programs to deduct $_____ from my paycheck to contribute to the Employee Crisis Program. I understand that this amount will be deducted from each paycheck effective immediately and will remain in effect until I choose to change or stop it.

OR

2. I authorize Archway Programs to take a one-time deduction of $_____ from my paycheck to contribute to the Employee Crisis Program.

OR

3. I wish to stop my payroll contribution into the Employee Crisis Program as soon as possible. I understand that any amount already deducted from my paycheck will not be refunded to me.

Print Name _____

Signature _____

Date _____

Please return this form to Human Resources once completed (HR@archwayprograms.org).