Foundation of Hope

PHO

CONWAY REGIONAL PHYSICIAN HOSPITAL ORGANIZATION

EMPLOYEE GRANT

The PHO Foundation of Hope's Employee Grant provides disaster relief and/or emergency hardship assistance for eligible employees of PHO member clinics. The grant is overseen by the PHO Foundation of Hope's Board of Directors, administered by the Foundation's Executive Director, and made possible through donations and fundraising activities. This program keeps all identifiable information strictly confidential.

Employees of PHO member clinics, who meet the guidelines, may apply. Need and resources available will be used to prioritize applications, as well as the date received. Grants will be made based on objective criteria and a fair selection process. Eligible grant applicants will be awarded within thirty days of board approval. When possible, the process will be expedited at the PHO Foundation Board's discretion.

There is no guarantee that applicants will be granted funds for which they apply. Funds will not go directly to the employee. The Foundation will pay approved invoices submitted by the applicant.

Grant Guidelines:

- Submit a completed application with all required information, and other documentation upon request.
- Applicant must have been employed for no less than 12 consecutive months with a member clinic and work an average of 30+ hours per week or be on leave through paid time off, or the FMLA.
- Applicant must have experienced a financial hardship due to illness, death, accident, crime, natural disaster, or other similar circumstances within the last 60 days.
- One application per household (not eligible again for three years after grant is awarded).
- Invoices applicant wishes to be paid, or items to be purchased, must be submitted with the application.
- Any expenses or repairs that are generally covered by insurance are not eligible (i.e. building repairs)
- If requested, proof of income, number of dependents, legal residency, and/or hardship must be supplied.

PHO Foundation of Hope

EMPLOYEE GRANT APPLICATION

CONFIDENTIAL

Name: _____

Address:_____

Email Address:_____

Phone/Text: _____ Does this # receive texts? _____

Married or Single? _____ Number of Dependents: _____

Employer Name: _____ Position: _____

Office Manager's Name: _____ Work Phone: _____

Length of Employment: _____ Average Hours Worked per Week: _____

Are you currently on FMLA? _____ Total Household Income: _____per year

Please give a detailed explanation of your hardship and how this grant may help. Add another page if necessary.

I certify that the information furnished above is true to the best of my knowledge and that the grant for which I am applying is for needs that cannot be met by any other source. I know that there is **no guarantee** that I will be awarded the grant for which I am applying.

Sign: _____ Date: _____

Please scan and email the application with attachments to jbrown.crpho@conwaycorp.net
Or mail to PO Box 10525, Conway, AR 72034.

For Office Use Only:

Date received: _____ Date award granted: _____ Amount Awarded: $_____ Approved: Y/N

Notes: