

# Employee Partners Care Foundation Request Form

<b>EP Name:</b>		<b>Club Number:</b>			
<b>Club Name:</b>		<b>Club Phone Number:</b>			
<b>General Manager:</b>		<b>Club Fax Number:</b>			
<b>Employee Partner Information</b>					
<b>Position:</b>		<b>If EP is not married, does he/she:</b>			
<b>Date of Hire:</b>		<input type="checkbox"/> Live Alone	<input type="checkbox"/> Live w/Roommate		
<input type="checkbox"/> Hourly	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Live w/Family			
<input type="checkbox"/> Salary	<input type="checkbox"/> Part-Time				
<b>Is Employee Partner married?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<b>Does the EP's spouse or significant other work?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A		
If so, what is his/her income?					
<b>Does the EP receive other financial support?</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A		
(including, but not limited to, governmental assistance, child support, or alimony)					
<b>Does the Employee Partner have children? (if so, how many and what are their ages?)</b>					
<b>Does Employee Partner have insurance? (check all that apply)</b>					
<input type="checkbox"/> Home	Deductible:	<input type="checkbox"/> Health	Deductible:		
<input type="checkbox"/> Auto	Deductible:	<input type="checkbox"/> Renters	Deductible:		
<b>Please DETAIL the Employee Partner issue. (Include dates and times, if possible.)</b>					
<b>What is the Employee Partner's major need for assistance?</b>					
<b>Did the Employee Partner and/or immediate family need to go to the hospital?</b>		<input type="checkbox"/> Yes	If yes, for how long?		
		<input type="checkbox"/> No			
<b>Has the Employee Partner missed work? If so, how many days?</b>		<input type="checkbox"/> Yes	If yes, for how long?		
		<input type="checkbox"/> No			
<b>How long will the EP be unable to work?</b>					
<b>Did the Employee Partner or family member die?</b>		<input type="checkbox"/> Yes	If yes, what are the funeral costs?		
		<input type="checkbox"/> No			
<b>Please itemize the Employee Partner's monthly expenses.</b>					
<b>Rent/Mortgage</b>		<b>Cell Phone</b>		<b>Groceries</b>	
<b>Car</b>		<b>Electricity</b>		<b>Student Loans</b>	
<b>Car Insurance</b>		<b>Gas (for heat)</b>		<b>Credit Cards</b>	
<b>Gas (for car)</b>		<b>Water</b>		<b>Other (please explain)</b>	
<b>Phone</b>		<b>Cable/Satellite</b>			
<b>Amount of assistance requested? (required)</b>					
<b>If requesting assistance due to a funeral or medical expenses, please submit the funeral bill and/or medical invoices (with vendor contact information) when submitting this request.</b>					

**Disclaimer:** The above information will be used by those involved with the Employee Partners Care Foundation for the limited purpose of this request and will be shared with the appropriate personnel for evaluation. The information will be retained at the corporate office but will not be maintained in the Employee Partner's personnel file. The Employee Partners Care Foundation will not discriminate based on race, color, religion, sex, and national origin.

\_\_\_\_\_  
Employee Partner's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
General Manager's Signature

\_\_\_\_\_  
Date

Fax # 972-888-7534

Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_