Heartland Dental Disaster Relief Fund

APPLICATION FOR ASSISTANCE

PURPOSE: This Fund helps Heartland Dental employees and supported dentists and/or eligible dependents who are experiencing economic hardship and are unable to afford housing, utilities, and other basic living needs because of a qualified disaster. Your co-workers and employer make these grants possible.

ELIGIBILITY: All Heartland Dental employees and supported dentist's who are employed part-time or full-time for at least 30 days prior to the qualified disaster are eligible to apply for grants from the Heartland Dental Disaster Relief Fund. In the case of death of the employee, then spouse or eligible dependents may apply. A copy of your paystub or payment statement should be attached to help verify employment. **An employee can only be approved for assistance once within a twelve-month period.**

GRANTS: The maximum grant amount available for assistance is $5,000; however, grant amounts vary based upon the nature of the event 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, please call 217-342-4988 with questions.

APPLICATION: To be considered for grant support, complete all five pages of the application. Print your name at the top of each page. Answering questions completely will help us process your request quickly.

- Attach current bills, invoices, and supporting grant documentation
- You will be notified of the status of your application at the email and mailing address you provide below within 7 days of receipt.

Send your completed, signed application with supporting documentation to amanda@enrichingourcommunity.org or mail to

Heartland Dental Disaster Relief Fund
Southeastern Illinois Community Foundation
PO Box 1211
Effingham, IL 62401

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 qualified disaster must have happened within the past 60 days.

A "qualified disaster" (as defined by IRS Publication 3833) includes (i) a disaster resulting from terrorist or military action, (ii) a disaster resulting from an accident involving a common carrier, (iii) a Presidentially declared disaster, or (iv) an event that the United States Secretary of the Treasurer determines is catastrophic.

SECTION B: INFORMATION ABOUT YOU

Applicant 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 qualified disaster, 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.

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 _____

Have you applied for this program before? ☐ Yes ☐ No If YES, date applied _____

SECTION C: PERSONAL INCOME

Required: Please attach copies of most recent pay stubs for each wage earner.

Your **annual gross** salary or wages (before/deductions)	$
Your spouse/partners **annual gross** salary or wages (before deductions)	S

	Prior to Qualified Disaster	**After Qualified Disaster**
A. Your average **monthly net** (after deductions)	$	$
B. Spouse/Partner's average **monthly net** income (after deductions)	$	$
C. Child Support Income **per month** (self and/or spouse/partner)	$	$
D. Social Security income **per month** (self and/or spouse/partner)	$	$
E. Disability income **per month** (self or spouse/partner)	$	$
F. Unemployment income **per month** (spouse/partner)	$	$
G. Alimony **per month**	$	$
H. Other income received **monthly** (please list):	$	$
Total Monthly Income (Items A - H)	$	$

Additional documentation of monthly 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

Type of Disaster _____ Date of Disaster _____
(Definition of qualified disaster on Page 1, Section A) ***(must be within past 60 days)***

Do you own or rent? □ Own □ Rent

Was the incident covered by insurance? □ Yes □ No If yes, is your application today being submitted after insurance coverage has been applied? □ Yes □ No If no, why not? _____

_____

Describe what has happened to cause your financial hardship _____

_____

_____

_____

_____

_____

_____

_____

How will this grant help you recover from the immediate financial crisis? _____

_____

_____

Please tell us anything else that would help in understanding the circumstances of the hardship you and your family are experiencing as a result of this qualified disaster.

_____

_____

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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 and not eligible for reimbursement or covered by insurance
- Home repairs necessary to restore or maintain home safety
- Essential appliances and furnishings
- Funeral expenses
- Car payments, repairs or car insurance

Grants <u>cannot</u> be made to pay for other, non-essential expenses such as:

- Reimbursements to employee or other individuals
- Accumulated financial issues or credit card debt
- Cable, phone or internet services, unless required by job
- Accidental damages due to negligence
- 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): Although the annual maximum grant amount is $5,000 annually, smaller sums may be awarded. 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.

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, 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 disaster expenses (hotel, building supplies, generator, etc.) and basic household 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 with questions.

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 Disaster Relief 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. Remember that the maximum amount any employee or family member can receive in a 12-month period is $5,000. It is likely that, from time to time, lesser amounts will be awarded. 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 Disaster Relief Fund
2701 South Banker, Suite 102A, Effingham, IL 62401
Phone: 217-342-4988
Fax: 217-342-4995