



GRANT APPLICATION INSTRUCTIONS

Financial Assistance

The HMSHost Cares fund was created as a resource to help employees who are facing financial hardship because of a qualified incident or personal financial hardships. An employee can only receive financial assistance or legal assistance once within a 12-month period. In the case of a denied application, the employee is eligible to submit a new application (for a new incident) after six months.

EMPLOYEE ELIGIBILITY: Subject to income limitations described below, a qualified HMSHost employee is one who is:

- regularly scheduled to work 20 or more hours per week; and
- employed by HMSHost working and residing in the U.S.; and
- actively employed or on approved leave of absence for no more than one year.
- In the case of death of the employee, eligible dependents—spouse/partner, children, parents or sibling—may apply.

In addition to the requirements above, the employee’s household income must meet or be below the 2017 federal poverty level (FPL) income numbers listed below:

\$12,060 for individuals	\$28,780 for a family of 5
\$16,240 for a family of 2	\$32,960 for a family of 6
\$20,420 for a family of 3	\$37,140 for a family of 7
\$24,600 for a family of 4	\$41,320 for a family of 8

QUALIFIED INCIDENTS: Qualified incidents are unexpected emergencies that arise outside of the employee’s control which causes a financial hardship for the employee’s family. A qualified incident is a result of a natural disaster (flood, earthquake, etc.) that occurs unexpectedly and causes unexpected bills. The reported incident must have occurred within 120 days of the application date.

PERSONAL HARDSHIPS:

- Fire, flood, or natural disaster, i.e. expenses not covered by insurance
- Military deployment
- Violent crime
- Death of an employee

Please note: Qualified incidents **do not** include: loss of household income due to cut back in house/overtime, unemployment, divorce, home foreclosure, disconnection notices, accumulated financial distress, or incidents that occurred 120 days prior to the application date.

APPLICATIONS: Applications to the Fund are reviewed by an internal committee of HMSHost Associates and will be treated in a confidential manner; however non-identifying statistical information will be reported to the company on a periodic basis. Fully complete applications will be reviewed within seven (7) business days. Submitting an incomplete application will delay review. Applications must be submitted within 120 days of qualifying incident. Employees are encouraged to keep a complete copy of the application for their personal records and to have on hand should we contact you with any questions.

FINANCIAL ASSISTANCE: The maximum amount available per employee, per incident is \$2,500. Grants may be awarded to help pay for expenses directly related to the qualified incident. If the application is approved, HMSHost Cares will issue the grant in the form of check(s) payable to the vendor(s) to whom the employee owes payment(s). The Fund does not issue checks to employees.

Grants **will not** be awarded for expenses, including, but not limited to: legal fees, insured property losses, insurable medical conditions, bills unrelated to the qualified incident, bills with service dates over 120 days prior to the application date, non-essential items or services, etc.

Please call 240-630-7087 if you have any questions as you complete your application.

Email, mail, or fax the completed application with required attachments to:

HMSHost Cares
 6905 Rockledge Drive
 Bethesda, MD 20817
 C/O Laura Sildon
 Email: laura.sildon@hmshost.com
 Fax: 240-694-4635

HMSHost Cares



Grant Application

Employee Name: _____

Employee Address: _____

City: _____ State: _____ Zip: _____

Employee Daytime Phone: _____ Alternate Phone: _____

Employee Email where you can be reached: _____

City where you work: _____ State where you work: _____

How did you hear about HMSHost Cares? _____

Have you applied for financial assistance from this fund in the past? Yes No

If yes, when? ___/___/___ What was the outcome? _____

Please provide a brief description of the event that caused the economic hardship:

Date of event causing the financial hardship: ___/___/___ (Must be within the previous 120 days)

How many people live in your household including yourself? _____ Adult(s) _____ Children (dependents)

This fund is a **last resort**. Please list all other efforts you have put forth to alleviate your financial hardship:

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 from a previous grant from the Fund. Grants will not be made before an employee has demonstrated an immediate need. This application will be treated in a confidential manner by HMSHost Cares; however, non-identifying statistical information will be reported to HMSHost 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 HMSHost. The fiduciary expectations of all HMSHost employees are paramount and a breach of these standards is ground for dismissal. Your signature below verifies that the information provided is true and complete and authorizes HMSHost Cares to obtain and/or verify all information necessary to process this application. In addition, you agree to provide the requested documentation supporting the information provided.

Employee Signature

Date

HMSHost Cares



PERSONAL FINANCIAL STATEMENT

Applicants must complete and sign a Personal Financial Statement showing an accurate picture of the family's monthly finances. Be sure to refer to the Eligibility Requirements page of the website for household income limitations.

Your assets:	Cash (in hand or checking)	\$ _____
	Savings account balance	\$ _____
	Other accessible cash	\$ _____
	TOTAL	\$ _____

Your monthly NET household income:	Employee's monthly wages	\$ _____
	Spouse's monthly wages	\$ _____
	Child Support received	\$ _____
	Disability Insurance	\$ _____
	Social Security/Pension	\$ _____
	Other income	\$ _____
	TOTAL Monthly Income	\$ _____

Your monthly living expenses:	Rent or Mortgage	\$ _____
	Utilities	\$ _____
	Food	\$ _____
	Child Support owed	\$ _____
	Medicine	\$ _____
	Car loans	\$ _____
	Gas/Incidentals	\$ _____
	Other	\$ _____
	TOTAL Monthly Expenses	\$ _____

YOU MUST PROVIDE TWO REQUIRED ATTACHMENTS TO PAGE 3

1. A copy of the HMSHost employee's most recent pay stub to prove current employment, and
2. The first page of the household's most recent federal income tax return(s), also known as 1040 or 1040EZ, showing the annual adjusted gross income.

IMPORTANT: If your annual gross income for the current year will be less than your previous year's tax return, please provide an estimate of your current annual income and reason for the change. You may be required to submit documentation from your employer verifying the information provided.

Your signature certifies that the information provided is true and complete.

Applicant Signature

Date

Applicant Name (PLEASE PRINT)

HMSHost Cares



QUALIFIED INCIDENT REPORT

Qualified incidents are unexpected emergencies that arise outside of the employee's control and causes a financial hardship for the employee's family. A qualified incident is typically a one-time event that occurs unexpectedly and causes unexpected bills. The reported incident must have occurred within 120 days of the application date.

Examples of incidents that DO NOT qualify included but are not limited to:

- Loss of household income due to cutback in hours or overtime, unemployment, divorce, or loss of child support
- Incidents that occurred more than 120 days prior to the application date
- Accumulated financial distress (income is not enough to cover regular monthly bills)
- Wage garnishments/Disconnection notice/Eviction notice (these are results of a financial hardship, not the cause)
- In some cases, lack of medical insurance and/or lack of home owner's insurance. Please call 240-630-7087 to discuss.

Please check the box that is appropriate for your incident:

- Natural Disaster (flood, lightning strike, house fire, tornado, etc.; primary residence only)
- Loss of life (employee, employee's spouse/domestic partner, dependent, parent or parent-in-law, or sibling)
- Catastrophic or Extreme Circumstances (an event that has happened within 120 days of the application date, does not fall into any of the above categories, and results in unexpected bills)

Describe the incident and how it prevents you from meeting your financial obligations (Attach additional pages):

Is there insurance that would help in this situation?

- Yes No

If yes, has a claim been submitted?

- Yes No

Did you or another household wage earner lose wages due to this qualified incident?

- Yes No

YOU MUST PROVIDE ONE REQUIRED ATTACHMENT TO PAGE 4:

You are required to substantiate (prove) your incident. Please attach appropriate documentation to show proof of the financial hardship (receipts, police/fire report, insurance report, note from a doctor, obituary, death certificate, etc).

HMSHost Cares



DETAILED LIST OF BILLS FOR CONSIDERATION

Please list each bill individually that you are asking the Fund to consider paying on your behalf. These bills must be directly related to the incident that you are reporting as causing a financial hardship for your family.

YOU MUST PROVIDE COPIES OF CURRENT BILLS IN THE SAME ORDER THEY ARE LISTED BELOW

- In the case of rent, a letter or invoice from landlord is sufficient.
- In the case of a natural disaster, a copy of a gift registry from a store like Target or Wal-Mart is sufficient if you are seeing help to replace essential household items not covered by insurance. Please call to discuss.

Vendor Name:	
Payment Address:	
Essential need provided: (rent, electric, medical, etc.)	
Amount owed:	\$
Account Number:	

Vendor Name:	
Payment Address:	
Essential need provided: (rent, electric, medical, etc.)	
Amount owed:	\$
Account Number:	

Vendor Name:	
Payment Address:	
Essential need provided: (rent, electric, medical, etc.)	
Amount owed:	\$
Account Number:	